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Graduate Program in Health and Rehabilitation Sciences
A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science
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EXPERIENCES OF MUSLIM WOMEN AS HEALTHCARE PROFESSIONALS IN
CANADA

(Spine title: Experiences of Muslim Women Healthcare Professionals)

(Thesis format: Monograph)

by

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Graduate Program in Health and Rehabilitation Sciences – Health Professional Education

A thesis submitted in partial fulfillment
of the requirements for the degree of
Degree Master of Science

The School of Graduate and Postdoctoral Studies
The University of Western Ontario
London, Ontario, Canada

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Abstract

The increasing rate of the Muslim population in Canada suggests the need to gain a better understanding of the cultural influences of Islamic faith and health related perceptions.

Although research has been done in exploring the experiences of Muslim women, much of this work has been focused on the experiences of Muslim women as recipients of healthcare or in different professional settings, with little attention paid to the challenges Muslim women face as service providers within the Canadian healthcare. This thesis enhances the understanding of the experiences of Muslim women healthcare professionals in Canada by bringing to light the struggles of a group considered to be in the margins of the society. A critical narrative perspective was adopted using in-depth interviews with four participants. The findings of this study provide valuable insights that may contribute to build a culturally competent healthcare environment in Canada.

Keywords: MuslimWomen, professionals, healthcare, hijab, Canada, critical narrative, Health Professional Education

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CHAPTER ONE

Introduction

In the near future Islam is expected to be the fastest growing religion in the West (Yosef, 2008). In the Arabic language, Islam means an individual's submissiveness to its Creator (Yosef, 2008). "In a religious context, it means submission to the will of God. Muslims submit to God's will and obey God's precepts as set forth in the Quran (The Holy Book of Islam) and transmitted to humans by Prophet Mohammed" (Yosef, 2008, p.285). In order to create a more culturally informed and meaningful environment, it is crucial to understand the Islamic practices and beliefs of this population. "Differences in the social and religious cultures of Muslims living in the West raise challenges for the healthcare professionals that go far beyond language to encompass worldviews, concepts of health, illness, beliefs, and work ethics" (Hammoud, White & Fetters, 2005, p.1307). This study will provide insights into the experiences of Muslim women as healthcare professionals in Canada in more detail to better understand the practices of the minority group considered to be in the margins of the society. Also, this study provides information that can help initiate changes which can enable the Muslim women to provide care in a more culturally competent and meaningful healthcare environment. Further this research can inform education, health care practices, and organizations about the need to implement effective organizational policies that can help address the issues of equality in order to promote future advancement opportunities (Yap and Konrad, 2009) for the Muslim women.

Background, Significance, and Purpose of the Study

Exploring the experiences of Muslim women healthcare professionals in Canada can help unravel broader social, historical, political, and cultural contexts. The growing numbers of Muslims in North America suggest the need to gain a better understanding of the practices of this population, specifically the Muslim women. "Islam is the world's second largest religion after Christianity. According to a 2010 demographic survey done by Pew Research Center, Islam has around 1.6 billion adherents, making up 23% of the world population" (The Future of the Global Muslim Population, 2011). In Canada, the current Muslim population is approximately 940,000 (The Future of the Global Muslim Population, 2011). "As Islam becomes increasingly visible as a public religious presence in what is still a Christian-majority country, many Islamic religious practices are being adopted, and adapted to, by Muslims living in Canada" (Williams & Vashi, 2007, p.269). The increasing rate of Muslim population in Canada highlights the need for healthcare providers and recipients to be better informed about the religious beliefs and health practices of this population. It is critical to gain a better understanding of the cultural influences of Islamic faith and health related perceptions to help promote a culturally competent healthcare environment.

In Canada, signs of being a Muslim woman such as veiling and other Islamic codes of modesty are seen as a symbol of oppression (Atasoy, 2006). According to an education review done by McBrien (2005):

Islam corresponds to the third type of stigma as defined by Goffman (1963/

1997), the tribal stigma of religion. Many of the girls cannot hide their Muslim affiliation, as the Islamic faith requires them to wear hijab, a scarf and conservative clothing. Others become obvious as they fast for the month of Ramadan or try to find secluded places for ritual prayers during the day. As a result, this stigmatized part of their identity is conspicuous and likely to bring rejection and discrimination from many members of the host culture. (p.336)

These viewpoints portray women as passive and submissive and Islam as a religion of women's oppression. However, the studies suggested “this perspective tends to naturalize woman's agency in enacting Muslim values” (Atosay, 2006, p.205). Exploring into the different ways Muslim women negotiate their identities and define their sources of strength and agency is crucial to gain a deeper understanding of their experiences.

The purpose of this study is to highlight the challenges faced by Muslim women as healthcare professionals and to explore the significance of the perceptions of people of the host nation about the Islamic and cultural practices, in shaping their experiences. I was also interested in exploring the perspectives of Muslim women pertaining to the choices they have made to redefine their position in the Canadian society, and the ways through which they challenged the stereotypes associated with being a veiled woman. By utilizing the critical theory approach, my intent was to unravel the different social, cultural, historical, and political factors that shape the experiences of these women. “However, it is beyond the purview of this study to find discernible patterns that can be generalized across larger populations” (Mishra & Shiraz, 2010, p.191). Exploring the experiences of Muslim women as healthcare professionals in Canada can provide insights into the diversity of this population. “Thus, it is important to understand that not all

Muslims enact their religious identities the same way; societal categories, level of education, cultural differences, and ethnicity all play a role in the formation and performance of Muslim identities” (Mishra & Shirazi, 2010, p.191).

Narrative inquiry approach provided the participants in this study with a space to voice their concerns and as a result, ascribe meaning to their individual experiences. Although limited in sample size, the narratives of the participants’ shed light on the misconceptions people have about the status of women in Islam. The narrative inquiry approach also allowed the participants to discuss in detail, in their own voice, the different modes of agency that act as sources of strength and empowerment in their lives.

This study can help draw attention to the unique experiences of Muslim women as healthcare practitioners in Canada and their perceptions of Canadians’ responses toward the practices of Muslim women in their workplace. This material can add to the knowledge base regarding the experiences of Muslim women healthcare professionals within the Canadian healthcare environment. The study may also help inform healthcare organizations, practitioners, policy makers, and educators about the unique challenges Muslim women healthcare professionals face in the Canadian environment. My objective is to address the issues of Muslim women as healthcare practitioners in order to help initiate changes that can lead to more opportunities and exposure for Muslim women in the West, and enable these professionals to provide more culturally meaningful, competent, and sensitive care.

Overview of the Thesis Layout

This study presents the different stages of the research process which contains seven chapters including this introduction where I discussed the background, significance, purpose of the study along with my personal story. In Chapter Two, I present the review of the literature highlighting its major themes focusing on the importance of the perceptions of the host nation towards the Muslim women, the role of hijab, and the emphasis on creating a culturally competent healthcare environment. I also discuss the gaps in literature and the significance and implications of this literature review for future research.

In Chapter Three, I discuss the critical narrative inquiry methodology and the methods used to conduct this study. I also present the research sample, the data collection, data analysis, and ethical considerations.

In Chapter Four I present the individual narratives. In Chapter Five I discuss the findings based on the emergent themes with a focus on the importance of hijab in shaping the participants' experiences; narratives about the lack of sense of belonging; gaining personal freedom through strategies of empowerment; their report on struggling with ethical contradictions between religious values and professional duties; and the role of the Canadian society in facilitating positive change.

In Chapter Six I discuss the findings from the preceding chapter in relation to previous literature on Muslim women in the West.

Finally, in Chapter Seven I present the implications of the study findings for Health Professional Education, healthcare organizations, and research. I reflect on my personal experience during the development of this dissertation and conclude the chapter by outlining the strengths and limitations of this project and the final considerations.

CHAPTER TWO

Literature Review

The purpose of this review was to a) summarize and disseminate current academic findings on the experiences of Muslim women in professional settings; b) examine the extent, range and main sources of evidence about the unique challenges of being a Muslim woman in Canada; c) identify significant gaps in existing knowledge base; and d) set priorities for future research within the subject.

Search Strategy

An integrative literature review approach was adopted. This approach helped “identify emerging topics that would benefit from a holistic conceptualization and synthesis of literature” (Torraco, 2005, p.357) to challenge and extend existing knowledge on the experiences of Muslim women as healthcare professionals in the West.

In this integrative review, a detailed search of the database was conducted for peer-reviewed articles published between January 1, 2000 and April 30, 2010: using

Scopus, and PsycINFO search engines. Only peer-reviewed articles were chosen because the focus is on primary research methods that bring to light the voices of active participants to highlight the focus on the specific scholarly topics (Kumar, 2008). The review used the following keywords: 'Muslim' 'women', and 'professionals', and where there was an option to expand the keywords, Muslim was expanded with the words 'Islam' and 'West'. Whenever possible the expression Muslim women were crossed with 'workplace', 'health', and 'veil'. The objective of the search was to identify all articles that present the experiences of Muslim women as professionals in a Western healthcare setting.

Since the searches did not yield a reasonable amount of material, papers that explicitly described Muslim women's experiences in different facets of life were then included instead of the previous focus on Healthcare practice. Studies were included if they a) focused on the experiences of Muslim women in a professional setting; b) examined the role of religion and cultural values in shaping the experiences of Muslim women; c) identified the perceptions of the people of the host country toward Islamic practices and d) explored the importance of health-related practices within the Muslim population. Exclusion of articles included those that were not written in English or published before January 2000, or did not address the gendered context of Muslim communities; and therefore did not serve the purpose of this study. However, articles that addressed the importance of Islamic values in a Muslim woman's life while receiving care were included, in order to provide insights into the different aspects of creating a culturally competent healthcare environment.

After the search, eleven articles were yielded which I examined based on the appropriateness of the abstracts (Spahn, 2010). Out of the eleven articles that were reviewed, only ten met the established criteria. The one article was then excluded from the review because it did not address the gendered context of Muslim communities. Studies were included if they provided information on the experiences of Muslim women in a professional setting in the West. In total ten studies were selected after careful revision. All of the included ten articles were published by authors working in Western countries. **Appendix A: Table one** summarizes the designs of the studies reviewed to reveal some of the gaps in literature on Muslim women professionals.

Mainly, the articles from this review focused on the social aspects of being a Muslim woman including acculturation, identity formation, and importance of their religious beliefs and practices. However, as previously indicated, there is no information regarding the experiences of Muslim women as healthcare professionals in Canada. This paucity highlights the need to better understand the challenges and unique practices of this population.

The faith of Muslim women and the health care environment

The role of religion, as a central aspect of many Muslim's women experiences, was reflected by several authors as indicative of an integral part in their professional lives. "Islam works within a holistic framework for health care in which physical, social, spiritual, and environmental needs of the patient are taken into consideration. Muslims are required to live a healthy and balanced life incorporating God, family, and community" (Fonte & Horton-Deutsch, 2005, p.41). The authors demonstrated the importance of the Islamic traditions in shaping the experiences of Muslims in their daily

lives. Hammoud et al. (2005) suggested “although Westerners tend to view themselves as human beings searching for spiritual experiences, Muslims are more likely to view themselves as spiritual beings having a human experience” (p.1308). Further, according to Odeh Yosef (2008), the notion of healthcare and health promotion practices are embedded in the Islamic faith. The author suggested that these findings may be explained due to the inherent Islamic belief system as outlined in the Quran which placed an emphasis on individual’s health.

Attitudes toward Muslim women

Four studies explicitly examined the perspectives and experiences of Muslim women who wear the veil in professional settings. This group of studies is summarized in **Appendix B: Table two**. The articles reviewed also bring the discussion of Western majority members’ attitudes toward the Muslim women and the Islamic veil which may play an important role in shaping their unique experiences in professional environments (Cole & Ahmadi, 2003 and Saraglou, Lamkaddem, Pachterbeke & Buxant, 2009). For example, the study conducted in Belgium by Saraglou et al. (2009) focused on “(a) the role of subtle prejudice/racism on the host society’s attitudes towards immigrants, (b) the role of values on acculturation, and (c) the role of religious attitudes on prejudice” (Saraglou et al., 2009, p.419). The authors highlighted the importance of the perceptions of people of host society in shaping the experiences of the Muslim women. Results from the previously mentioned study revealed that the majority of the Muslim immigrants “are seen particularly negatively” (Saraglou et al., 2009, p.419). The findings of this study indicated that the Muslims were subjected to some form of prejudice, or discrimination

due to preconceived notions people of the host society have about Islam. The authors found that:

These groups are considered inferior in a rather essentialized way; they are disliked and perceived as less human in terms, for instance, of emotions. Further they explain that these negative attitudes and behaviors are indeed due to out-group prejudice and subtle racism and not only to political conservatism. (p.420)

The findings of this study shed light on the interpretation that negative attitudes can be associated with the perception people have of Islamic civilization which is seen as under developed. Indeed, the authors suggested that “the Muslim woman is often seen as a sign of woman’s submission to men and authority and as reflecting less developed, pre-modern values and worldviews in comparison to the West, which is perceived as valuing freedom and personal autonomy” (Saraglou et al., 2009, p.420).

Attitudes toward veiled Muslim women

Some authors investigated aspects related to the practice of veiling which is prescribed by Islamic code of modesty, and also acts as an identity marker that can play an integral role in shaping the experiences of a Muslim woman. Hammoud et al. (2005) stated:

Islam commands both sexes to dress modestly, to maintain a moral social order and to protect a person’s honor – so the basic requirement for Muslim women is that clothes are neither transparent nor shape-revealing and that hair, arms and legs are covered, especially in the presence of any adult male who is not in the woman’s direct lineage. (p.1309)

From this perspective, it could be stated that veiling is an important aspect of modesty leading to a more virtuous human code of conduct. In the reviewed articles, the practice of veiling, along with a pursuit toward virtuous behavior, was described as expected and used by the Muslim women as a means to strengthen their relationship with God (Saraglou et al., 2009). However, the authors demonstrated the importance of veiling in redefining the role of Muslim women in the host society. From the previously mentioned articles (Hammoud et al., 2005 & Saraglou et al., 2009) it can be recognized that the Western negative attitudes are more intense toward Muslim women who choose to wear the veil.

Muslim women play the role of outsider/insiders within different communities in order to redefine their identities and to negotiate a sense of belonging in relation to the idea of the hijab (Cooke, 2008). According to an American study done by Cole and Ahmadi (2003), Muslim women students wearing the hijab (the veil), “reported that some peers and faculty held negative misconceptions about veiled women” (p.49). The veil in a Western society is considered to be a sign of oppression and submission to men. The findings suggested “that the veiled woman was perceived as docile, oppressed, and as having limited English speaking abilities. Although these perceptions are more grounded in exaggeration than in fact, the authors showed that these misrepresentations persist” (Cole and Ahmadi, 2003, p.49). Accordingly, focusing on the perspectives of Muslim women who wear the veil on college campuses, the authors found more negative attitudes toward veiled Muslim women. In fact, the findings from this study suggested that the practice of veiling affected the Muslim women’s interaction on campuses because they were perceived as extremist. “As a result, the

authors caution that it might lead to varying levels of work-related and social discomfort, isolation and distrust for veiled women” (Cole & Ahmadi, 2003, p.57).

From the findings of the previously mentioned study, it could be suggested that the social misperceptions related to the practice of veiling play an integral role in shaping the experiences of a Muslim woman. Cole and Ahmadi (2003) reported that “the misconceptions toward the veil indicate that the practice of veiling is largely misunderstood and often seen as a woman’s inferiority to men” (p.57). The authors demonstrated the veiled women were subjected to prejudice and stereotypes. “Accordingly, the idea that all women are oppressed through the practice of veiling is strongly conveyed whether through stereotypes, misinformation, or limited information” (Cole & Ahmadi, 2003, p.58). Two studies explicitly suggested the common misconceptions and stereotypes that the women encountered are because of the limited knowledge people of the host nation have about their beliefs and practices (Cole & Ahmadi, 2003 and Saraglou et al., 2009).

The previously mentioned study done by Cole and Ahmedi (2003) explored the perceptions and experiences of eight Muslim students who wear the veil on College Campus in the United States. The results showed that the experiences of Muslim women with a veil varied according to the local context and circumstances. Of particular interest, the authors suggested that Muslim women have “similar perceptions of how they are viewed by the majority of the community, because people in the campus environment seemed misinformed or had little knowledge about Muslims and the hijab” (Cole & Ahmadi, 2003, p.58).

In contrast, the role of family/community in relation to religion also plays an integral role in shaping the experiences of Muslim women. Two studies (Cole & Ahmadi, 2003 and Dwyer, 2009) pointed out that it is noteworthy to mention that the “act of veiling can also be affected by culture, primarily rooted in one's national heritage and place of residence” (Cole and Ahmadi, 2003, p.56). The authors emphasized that the importance of cultural norms also play a crucial role in terms of the way the Muslim women viewed the practice of veiling. The authors found that “this cultural influence may likely heighten and complicate the religious, personal, and political significance of the veiled Muslim women” (Cole & Ahmadi, 2003, p.56). These authors stated that the act of veiling might create differences within the Muslim community, where the veil might be looked down upon in some cultures due to the negative connotation attached to it. For instance, contrary to popular, yet prevalent belief, a Muslim woman who chooses to wear the hijab might have to face some opposition from her family because, as Dwyer (2009) suggested, it might be undesirable in some cultures. Hence, for a Muslim woman who goes against her parents’ desire, wearing the veil could assert her own independence in relation to her parents and community. The authors found that wearing the veil may have a positive impact on the Muslim women’s lives because it helps them redefine themselves in their own manner. According to Dwyer (2009) Muslim women who chose to wear the veil sometimes meant challenging parental or cultural ideas about female behavior and appearance – which varies from culture to culture. From the previous literature it could be suggested that the hijab plays an important role in helping the Muslim women renegotiate their source of agency in a Western environment (Bartkowski & Read,

2000; Byng, 2010; Cole & Ahmadi, 2003; Dwyer, 2009 and Korteweg, 2008).

According to a review done by Korteweg (2008), “agency requires an underlying sense of self, as well as an ability to assess the impact of one’s actions on future outcomes and the impact that past actions have had on present conditions” (Korteweg, 2008, p.437). From the perspectives of the Muslim women, hijab allowed them to redefine their identity within different contexts.

Importance of creating a culturally competent health care environment

Understanding the Western majority’s attitudes toward Muslim women is an important issue for improving intercultural relations (Saraglou et al., 2009). The review done by Hammoud et al. (2005) emphasized the importance of building a culturally competent healthcare environment. For example, the authors suggested that “unintentional violation of customs, rituals or deeply held beliefs can prevent the establishment of relationships that allow healthcare providers to begin exploring important issues with patients from different cultures” (Hammoud et al., 2005, p.1308). Further, research by Fonte and Horton-Deutsch (2005), examined the importance of cultural awareness in the United States. According to the study, “cultural awareness requires the nurse to be respectful and sensitive to the values, beliefs, and practices of others. This, in part, can be learned through the examination and evaluation of one’s own cultural values, biases, and stereotypes” (Fonte & Horton-Deutsch, 2005, p.42). The authors suggested the importance of knowledge exchange in order to create a more culturally safe environment. “Cultural knowledge includes, for example, understanding healthcare beliefs, interpretation of health and sickness, ethno-psychopharmacology, and gender role expectations in diverse cultures” (Fonte & Horton-Deutsch, 2005, p.42). The

findings of this study highlighted that understanding human relations from the cultural perspective will enhance the cultural competency of an organization. According to Browne and Varcoe (2009) culture is “a relational aspect of ourselves that shifts and changes over time depending on our history, social context, past experiences, gender, professional identity and so on” (p.36). Hence, cultural knowledge will involve a clinical connection that encompasses different cultural groups (Fonte & Horton-Deutsch, 2005).

Further, certain religious requirements might interfere with the more traditional western approaches that providers use to establish rapport with patients. The review done by Odeh Yosef (2008) on the healthcare beliefs of Arab Americans further revealed some of the cultural barriers related to modesty, and gender preferences in seeking and accepting healthcare from male or female providers.

For example, some Muslims, especially the ones who observe the hijab, may not shake hands with someone of the opposite sex. Without an understanding of and respect for these cultural norms, people might unintentionally alienate Muslim women, despite intentions to make them feel part of the group. (Hammoud et al., 2005, p.1309)

According to the previously mentioned review done by Odeh Yosef (2008), some health-related and social practices might provide challenges to Muslim women as service providers in the Western world. The author concluded that the Muslim women who choose to serve as healthcare practitioners in the West must not only address their own specific cultural or religious obligations, but also need to gain a deeper understanding of their surroundings in order to provide better healthcare (Odeh Yosef, 2008).

The importance of creating a culturally competent health care environment is further reinforced in a study done by Kulwicki, Khalifa and Moore (2008), based in the United States post September 11 event that explored the unique additional hurdles faced by Arab American nurses. The authors stated that “Arab American women were almost twice as likely as men to be verbally and physically assaulted” (Kulwicki et al., 2008, p.135). The findings of the previously mentioned study demonstrated that discrimination was a major source of concern. The authors found that “Muslim women who wear the hijab face greater vulnerability to hate crimes and discrimination because the headscarf is an identifying piece of religious dress in American society” (Kulwicki et al., 2008, p.135). Here, the importance of hijab is emphasized as it plays an important role in shaping the experiences of Muslim women. The study claimed that a woman who wears the hijab experiences “... discrimination such as being called names, being intimidated, and have heard negative comments about wearing a hijab and religious practices” (Kulwicki et al., 2008, p.139). Further, the studies suggested that due to prescribed traditional practices of the Islamic faith such as fasting, taking time off for prayers throughout the day, or wearing hijab might create the impression that this population could alter public space (Kulwicki et al., 2008). It draws light on the interpretation that Muslim women can be at a substantial disadvantage due to negative attitudes that are being perpetuated through media, which may be seen as a cause for concern, because it could limit their freedom and independence in terms of practicing their faith, as well as hamper their work performance.

The previous literature also discussed the importance of promoting cultural workplace safety/sensitivity in the healthcare environment, because most of the Muslim

women nurses (in the US context) felt their work performance suffered and had patients and their families refusing their care more often (Fonte & Horton-Deutsch, 2005; Hammoud et al., 2005 and Kulwicki et al., 2008). According to a research study done by Fonte & Horton-Deutsch (2005), cultural safety in the workplace encourage people to be “respectful and sensitive to the values, beliefs, and practices of others” (p.42). The findings from another study done by Kulwicki et al. (2008) suggested:

There is a need to further examine discrimination against Arab Americans following 9/11 and its effects on their work performance and mental health. Discrimination in the workplace creates a hostile environment that will affect not only Arab Americans’ work performance but also their mental health. (p.139)

The findings from the previously mentioned literature highlighted the importance of creating a safe work environment for the Muslim population due to the political conflict post September 11th event. Thus, the authors concluded that it is important to “bring to light the importance of creating a peaceful and safe environment in the workplace that is free of hostility and discrimination” (Kulwicki et al., 2008, p.138). Hence, these findings can help address cultural diversity and integrate that knowledge into future health promotion services which is crucial to obtaining successful health outcomes, thereby, enabling the Muslim woman to provide more culturally competent healthcare.

Discussion

Although very limited, the literature sheds some light on the role of religious beliefs and cultural values in shaping the experiences of Muslim women as recipients of

healthcare and some information regarding the experiences of Muslim women service providers-nurses.

Among the potential reasons for the paucity of research in this area could be the difficulty to find Muslim women in diverse healthcare settings who are willing to participate in research. For instance, issues such as modesty, or other social constraints and religious restrictions might discourage the Muslim women to voice their concerns. As a result, the breadth of this literature may be hampered.

Much of the current research related to the experiences of Muslim women in the West focus on the challenges faced by Muslim women as healthcare recipients and the barriers they face when trying to access care. Missing from this body of work, however, is consideration of the Muslim women's perceptions as healthcare practitioners and the unique challenges they may have to face in the work environment because of their Islamic values.

Further, many researchers have tended to characterize this population as a homogeneous group. "This homogenization enabled the gendered racialization of the very diverse Muslim communities", because it negates the importance of individual experiences, perceptions, socio-economic status, education, level of faith, professional competency, citizenship status, or other social locations and identities (Korteweg, 2008, p.436). These factors play an integral role in shaping the experiences of Muslim women and need to be addressed in order to help deconstruct social myths that are associated with being "veiled".

In addition, much of the debates surrounding the Muslim women and the veil "did not address various facets of agency, but rather questioned Muslim immigrant

women's capacity to act in a self-interested way" (Korteweg, 2008, p.438). The author suggested the different forms of agency through which the Muslim women derive strength and support. She stated:

The distinction here is between seeing agency solely as resistance, which captures actions that explicitly aim to undermine hegemony, and embedded agency, which captures practices that do not have this explicit aim, yet still reflect active engagement in shaping one's life. (Korteweg, 2008, p.438)

The importance of understanding different forms of agency in the lives of these women is crucial to gain a better understanding of the choices they make. "Here, by looking at different facets of embedded agency would have given us a richer sense of how practices of domination and subordination, such as those associated with Islam, structure the subjectivity underlying the Muslim woman's capacity to act" (Korteweg, 2008, p.438). Further, it should be recognized "that agency is central to the action-model, which attempts to grasp individuals' capacities to act independently of structural constraints, or against them" (Bilge, 2010, p.12). Thus, in order to gain a better understanding of the concept of agency, it is important to look at the different contextual factors such as economic, political, cultural and ethnicity that shape the experiences of Muslim women. Korteweg (2008) highlighted:

Such assessments require us to understand agency as embedded in multiple social forces. For instance, the continuing debates on the hijab often construe the wearing of the veil as a sign of limited agency and of the incompatibility between Islamic and Western values. In this process, Muslims also become ethnically "other" and often actors both within and outside Muslim communities ethnicize

religion through appeals to women's proper role in the family, their bodily comportment. (p.439)

Hence, the previously mentioned review may provide insight into the different forms of agency in the lives of these women. It may also "further our understanding of how various institutions can work to support rather than undermine women's varied expressions of agency" (Korteweg, 2008, p.451).

As some of the reviewed studies have shown, Muslim women do not necessarily associate veiling with oppression or in ways that circumscribe their capacity to act (Bartkowski & Read, 2000; Byng, 2010; Cole & Ahmadi, 2003; Dwyer, 2009 and Kortweg, 2008). The authors suggested that looking at the practice of veiling solely as a sign of oppression or limited agency of the Muslim women undermines the importance of other factors in shaping the experiences of these women. Byng (2010) stated that "there are social and political meanings associated with veiling that go beyond religious practice and gender inequality" (p.110).

Droogsma (2007) defined hijab as a piece of cloth that "covers most of a woman's upper body, including the head, ears, neck, and chest" (p.296). As the previous literature indicated, for many Muslim women donning hijab is a conscious choice to assert their independence and redefine their position in the Western society. "In this light, knowledge about veiling among Muslim women must be extended beyond the classic topics of patriarchy, Islamic feminism, religiosity, and identity to include the national identities of Western nations, and the assimilation of Muslim minorities" (Byng, 2010, p.110).

Many studies also discussed how the act of veiling for the Muslim women shapes their experiences in positive ways. For instance, for some Muslim women, veiling increases discrimination against them; however, it also mitigates discrimination because it provides them with a means of self-definition, and empowerment because “veiling affirms their agency and removes them from the sexual gaze of men” (Byng, 2010, p.111).

Moreover, the studies highlighted the importance of media in building stereotypes and feeding misconceptions against the Muslim women (Byng, 2010 & Kulwicki et al., 2008). “Media representations are central to creating common sense understandings of a wide range of social events and issues including veiling by Muslim women in Western nations” (Byng, 2010, p.111). The studies discussed the political significance of September 11th event in the United States in creating the hostile response towards the general Muslim population (Byng, 2010 and Kulwicki et al., 2008). “The attacks of September 11 in 2001, in the United States brought this pattern in media representations of Muslims and Islam under severe scrutiny” (Byng, 2010, p.111).

According to the findings of the above mentioned literature, the media such as news channels, and print media helped perpetuate negative images of Islam and generalizing the practices of all Muslims. “More generally, the media have represented Islam and Muslims as culturally incompatible with the values, norms, and interests of Western nations” (Byng, 2010, p.111). The findings from the studies demonstrated the negative impact media had on the lives of the Muslim women living in Western society, post 9/11 event. The articles bring to light the negative consequences of the misperceptions created by the media toward the Muslim population, specifically, the

Muslim women. “If media representations create a socially shared common sense that excludes representations of Muslim identity from the western public life, then that community is limited in its ability to experience its identity, like other religious groups, to advance its interests” (Byng, 2010, p.125). This may lead us to reflect on the current situation of Muslim women in the West, and ponder over whether it is the Islamic values that limit Muslim women's agency in a western society or is it the media pressure that acts as a barrier to their achievements?

Further, the study done by Bartkowski & Read (2000) indicated the importance of how the “pro veiling and anti-veiling discourses have carved out distinctive positions for Muslim women and their unveiled counterparts” (p.412). The studies demonstrated how the notion of veiling can help have a positive impact on the Muslim women’s lives. For instance, veiling helps foster a “strong sense of sisterhood within the Muslim women community, because these women forge ties of tolerance with their sisters in Islam (veiled and unveiled), build bridges across the cultural terrain of veiling and contribute to contemporary Islamic culture” (Bartkowski & Read, 2000, p.412).

Summary of the Literature Review

The findings of this literature review underline the experiences of Muslim women in the West and offer insights into the social misconceptions of being a veiled Muslim woman. Similar to the findings of the study done by Haldenby, Berman, & Forchuk (2007) on a group considered to be in the margin of the study, it could be stated that “moving the issue beyond the individual level allows for the consideration of how

contextual factors influence” the experiences of Muslim women as healthcare practitioners in the West (p.1243). Further, the findings of previous literature highlight the importance of political conflict post 9/11 event which is heightened by the media’s portrayal of Islam in a negative light. This literature review brings to light the importance of the perceptions of people in social interactions and its impact in shaping the experiences of a minority group (Haldenby et al., 2007). Also, this literature review can be used as the basis to understand the need to explore the unique experiences of Muslim women as service providers and the challenges they have to face in the Canadian healthcare environment

Implications for Research

There have been many studies done on the experiences of Muslim women receiving healthcare, yet the experiences of Muslim women as healthcare providers in the West are missing from this body of work. The literature review suggests “there is a need for a deeper, nuanced understanding of Non-Western and Islamic cultures to ground health care practice more deeply” by broadening their knowledge of global gender, religious and cultural issues (Critelli, 2010, p.236). The unique perspectives of Muslim women service providers may provide valuable information in helping create space for this group to voice their concerns. The purpose of this study is to explore the experiences of Muslim women as healthcare professionals in Canada and the perceptions of local Canadians toward their cultural and religious practices in order to gain a better understanding of how it can enable the Muslim women to provide more culturally meaningful and sensitive care within the globalized contemporary healthcare context.

CHAPTER THREE

Research Methodology and Methods

In this chapter I provide the rationale for choosing the specific theoretical /philosophical components in my study. The study used critical narrative inquiry

approach to explore the experiences of Muslim women healthcare professionals in Canada. I also present the specific methods that were used in this study. Finally, I conclude with a discussion on how quality considerations were addressed.

Research design and theoretical/philosophical approach

This study is situated in the critical theory paradigm. The research design chosen for this study is the critical narrative analysis. This approach utilizes key characteristics of critical social theory with narrative inquiry (Haldenby, et al., 2007).

The study was conducted through a critical theorist lens that ontologically acknowledges an “apprehandable reality that is over time shaped by economic, political, social, cultural, ethnic and religious factors” (Guba and Lincoln, 1994, p.110). I was interested in learning how critical theory reveals the power imbalances that are constructed in society pertaining to gender, race, class, culture, and economics (Hewitt, 2007). By using the critical theory approach I wanted to shed light on the dominant forces that shape the experiences of Muslim women as healthcare professionals in Canada. According to Kincheloe & McLaren (2005) “oppression has many faces and that focusing on only one at the expense of others (e.g., class oppression vs. racism) often elides the interconnections among them” (p.304). Hence, my goal in this study is to unravel the interconnections between religion, culture, and gender that shape the experiences of Muslim women healthcare professionals.

Further, critical theory incorporates multiple lenses of analysis which may add to the understanding of the experiences of Muslim women that could lead to social change. Kincheloe & McLaren (2005) stated that “critical theory assumes that the facts can never be isolated from the domain of values” (p.304). This perspective also enables the

researcher's values to play an integral role in the analysis process. Hence, in this case, the "researcher and the participants are interactively linked, with the acknowledgement that the researcher's values will influence the inquiry. Findings are therefore value-mediated" (Guba and Lincoln, 1994, p.110).

It makes sense to use the dialectical approach to do this study because through a critical theory lens it is implied that "knowledge does not accumulate in an absolute sense; rather, it grows and changes through a dialectical process of historical revisions that continuously erodes misapprehensions and leads to more informed insights" (Guba & Lincoln 1994, p.110). The narratives of the Muslim women would create space for dialogue which would provide useful insights about the ways through which Muslim women redefine their role in the Canadian society.

I also adopted the critical hermeneutic approach to understand the meanings embedded the participants' narrative. A critical hermeneutic approach enabled me as a researcher "to make sense of what has been observed in a way that communicates understanding" (Kincheloe & McLaren, 2005, p.311). Critical hermeneutic analysis helped me examine this research through understanding individual lived realities that reveal the power relations that exist within broader social, political, and historical contexts (Haldenby et al., 2005). Hence, from the critical theory perspective, hermeneutic analysis draws attention to cultural fallacy highlighting various power imbalances that exist within cultural and social contexts " (Kincheloe & McLaren, 2005).

The participants for this study belong to a group considered to be in the margins of the society. This research design provided the Muslim women with a space to voice

their perspectives and concerns. In addition, this research study may provide the readers with an opportunity to gain familiarity with the participant's context to look beyond their veil and gain a deeper understanding of the experiences of Muslim women healthcare professionals (Haldenby et al., 2007). At the same time, the participants' individual, subjective experiences were explored with particular attention to the manner by which those experiences are shaped by social misconceptions and its impact on their religious and professional practices (Haldenby et al., 2007).

Narrative inquiry combined with critical social theory approach allows the voices of the participants to be heard in ways that can lead to empowerment (Kincheloe & McLaren, 2005). Hence, a critical narrative analysis has been undertaken using "language as the medium that reflects meanings, which are understood as the groundwork of reality" (Haldenby et al., 2007, p.1237). Critical theory allows the research to become transformative in nature (Kincheloe & McLaren, 2005), "because you do not merely study an object to gain greater understanding, but instead struggle to investigate how individuals and groups might be better able to change their situations" (Wolgemuth & Donohue, 2006, p.1025).

In this case, providing Muslim women with an opportunity to voice their concerns through their stories will serve a few purposes. First, it adds credibility to the study because it allows the researcher to reflect on the experiences of participants in a believable way (Whittemore, Chase & Mandle, 2001). Second, it enables the reader to better engage in the topic being discussed, as it gives one an opportunity to understand the implications of being a Muslim women healthcare professional in the West. Third, it "makes room for reader's alternative interpretations" (Chase, 2005, p.665) that can

enable one to draw their own conclusions or gain deeper insights into the topic being discussed. Lastly, it provides a framework that enables the researchers to stay focused on specific issues they are exploring - in terms of knowing what is relevant and how it can help address various power dynamics within social, political and historical contexts. However, from a critical perspective, “language is a powerful medium that could validate particular research strategies” (Kincheloe & McLaren, 2005, p.310). Thus, as a critical researcher, my goal was to raise awareness through paying particular attention to these power dynamics (Kincheloe & McLaren, 2005).

In addition, as a narrative researcher, I understand that framing a research puzzle is part of the process of thinking narratively.

“Each narrative inquiry is composed around a particular wonder and, rather than thinking about framing a research question with a precise definition or expectation of an answer, narrative inquirers frame a research puzzle that carries with it a sense of search...”. (Clandinin & Huber, p.10)

The narrative research creates space for a sense of discovery to emerge through highlighting various emotions and interpretations. Hence, “the knowledge developed from narrative inquiries is textured by particularity and incompleteness; knowledge that leads less to generalizations and certainties and more toward wondering about and imagining alternative possibilities” (Clandinin & Huber, p.14).

It also makes sense to use narrative inquiry approach as it incorporates various aspects of participants’ stories based on their own individual experiences revealing power dynamics and social patterns that exist in society (Haldenby et al., 2007). Further, it enables the researcher to uncover the broader social and political factors that play an

integral role in shaping the experiences of Muslim women, which can help create more exposure for the Muslim women in the West. “In this way, greater degrees of autonomy and human agency can be achieved” (Kincheloe & McLaren, 2005, p.308). Hence, critical narrative approach was deemed appropriate to address the goals of this study, which are stated below:

1. How do Muslim women narrate the experience of being a Muslim woman who is a healthcare professional in Canada?
 - a) How does gender shape these experiences?
 - b) How do religious and cultural influences shape their experiences?
2. What are the perceptions of local Canadians toward the Muslim women and their religious practices, according to the participants?

Research Methods

Participant/Recruitment

This study included Muslim women (veiled or not) who are healthcare practitioners. Four Muslim women who worked in diverse healthcare settings in a Southwestern city of Ontario were recruited to participate in the study. All of the four participants selected were physicians at different stages of their career. All of the participants interviewed were trained in Canada. One of the participants was an international trainee, two came to Canada as immigrants and one was raised in Canada.

A relatively small sample size was sufficient based on the needs of this study, as in narrative research “depth rather than breadth in data collection is sought in order to

make the findings more meaningful and ‘information-rich’” (Holloway & Freshwater, 2007, p.70). In addition, participants who were recruited had at least six months of work experience in a Canadian healthcare setting, and were willing to share their reflections and perceptions about their experiences. An attempt was made to recruit participants from diverse ethnic and cultural backgrounds within the Muslim community in order to increase the scope of social patterns and culture. In order to enhance sample diversity, information about this study was shared with community centers that are organized by members of different ethnic groups within the Muslim community who provide services to that particular community. Hence, sample criteria were comprised of: work experience, ethnicity, nationality, educational, and religious background.

Purposeful sampling was used to achieve diversity in the sample. As the rich descriptions of the narratives allowed the researcher to unravel individual participants’ voices within different contexts (Shields, 2004). In qualitative research, trustworthiness is established by setting specific criteria to determine the appropriateness of one’s sample (Shields, 2004). Purposeful sampling allowed the researcher to select participants according to the aims and demands of the study (Shields, 2004). The participants were recruited based on their willingness to share their experience and to explore how those experiences have impacted their professional practice. Posters and study information were posted on community bulletin boards (Shields, 2004) such as the Muslim community center and Mosques. Word of mouth, personal invitation, and snowball sampling were also used to find participants (Shields, 2004) from diverse ethnic backgrounds in various healthcare settings.

Recruitment and Consent process

Recruitment began once ethics approval was obtained from the University of Western Ontario's Research Ethics board. All potential participants received an explanation of the study. Interested participants were then invited to have an initial informal conversation with me, where I informed them about the purpose of the study in depth indicating and discussing any vulnerability they may fear prior to inviting them for an interview. Those who met the eligibility criteria and agreed to participate in the study were then provided with a consent form and booked for another meeting. At the beginning of the initial interview, I went over the important details about the project in assuring that participants' privacy and autonomy would remain intact throughout the study process. Then the participants were asked to sign the consent form (**Appendix C**) and choose a pseudonym to remain anonymous for the entire study. If, as a researcher I felt the participant demonstrated any sign of discomfort during the interview, I reminded them of their right to withdraw from the study at any point in time.

Data collection

Semi-structured in depth individual interviews that are dialogic and interactive in nature were conducted. The interviews lasted one and one-half hour and took place at the participants' choice of location. All the interviews were conducted in the participants' work office based on their request. An interview guide that helped me as a researcher to remain on track was used (see **Appendix D**). I used the interview questions only as a guide or to probe the participants to share more information about their experiences. Mainly, the interview questions revolved around the challenges Muslim women faced in the Canadian healthcare environment; perceptions of people

of the host nation such as the patients or other coworkers toward the Muslim women; importance of hijab in shaping the experience of these women (if applicable); strategies women used to overcome hardships; and their sources of strength and agency. Through the use of open-ended questions participants were free to begin and end their story at any point in time. Probing questions pertaining to the attitudes of people of host nation were specifically asked in order to help me better understand the experiences of Muslim women in a Western healthcare setting. Finally, I did not directly ask the participants' about their experiences of wearing hijab, because I felt it might offend them since it is a very sensitive topic. Hence, in fact I only probed the topic regarding hijab when participants raised it.

New knowledge was co-constructed between the researcher and the research participants. "As critical theory assumes that the standards of truth are always social" (Haldenby et al., 2007, p.1237). After the interview, field notes were taken, which assisted me in revising the interview guide as the study progressed as well as assisting in data analysis (Patton, 2002). All interviews were audio taped and transcribed verbatim.

Data analysis

Data analysis was guided primarily by Chase's work on narrative inquiry. Narrative inquiry approach illuminates the importance of communication by utilizing various linguistic strategies (Chase, 2005). As Chase stated, narrative inquiry approach helps explore the different ways stories take place in between the researcher and narrator's interaction, "how they make sense of personal experience in relation to culturally and historically specific discourses, and how they draw on, resist or transform

these discourses as they narrate their selves, experiences and realities” (Chase, 2005, p.659). Since, there is no one accurate method to follow in narrative inquiry, this approach provides the researcher with the space to interpret things in different ways to make meaning out of the interpretations (Pavlish, 2007). As a result, it allowed me to explore “the interactional processes in the interview as well as linguistic and thematic patterns which emerged from the narrative strategies people created in relation to their environment” (Chase, 2005, p.659).

In this study, I analyzed participants’ narratives in two stages. In the first stage, I viewed the participants’ narratives as the raw data that reflected participants' situated truths about being a Muslim woman healthcare professional in Canada. In the second stage, the transcribed interviews were analyzed. Attention was paid to both the content of the story and the way in which it was told (Lieblich et al., 1998). This analytical approach offers the advantages of highlighting the various power relations and imbalances within their social contexts that play an integral role in shaping the experiences of the participants (Shields, 2004).

First Stage

In the first stage of the analysis, all interviews and reflections were transcribed verbatim by myself. Each interview took approximately 10 hours to be completely transcribed. The recordings were played multiple times to ensure data transcription accuracy was captured. Once, the interviews were transcribed, I placed the participants’ stories in chronological order because, as Wengraf (2001) suggested participants may share their stories in a non-sequential order, thus requiring the researcher to order the transcripts from the beginning to the end of the story. Dates and events were labeled

using a temporal line using Microsoft Word which included: getting into the Canadian healthcare system; experience during residency training; and transition from training towards a more established career. For some participants, having a more established career meant starting their own practice, while for others it meant specializing in more rigorous fields in Medicine. The transcripts that matched each section of word document with the previously mentioned labels were cut and pasted onto that piece. Finally, when all the pieces were put together in each section, I started analyzing the participants' narratives and reorganized the pieces of the transcript, based on my own understanding and interpretations of their narratives, by placing them on a new blank word document which I named Participant's Story. After the stories were compiled for all the participants, I began to explore the stories for emergent themes which included issues or words that were repeated throughout the text in multiple forms. I read through the stories many times, word-by-word to ensure that the essence of the participants' text is incorporated in the analysis. As I was going over the stories, line by line, I started coding the feelings or situations that the participants' repeated or described in detail. For instance, the importance of hijab was raised in different contexts from the participants' point of view, which helped me better understand the various meanings participants' ascribed to the role of hijab in shaping their experiences as healthcare professionals. I also discussed these stories with my supervisor to further guide me with the analysis. The data analysis was iterative and diverse in nature, because I examined the data from different perspectives, which "...may reveal and construct the complexity" (Phoenix, Smith & Sparkes, 2008, p.9) and diversity of people's experiences of being Muslim women healthcare professional in the West. Throughout the analysis phase, a critical lens

was applied to highlight various power dynamics and its impact on the experiences of Muslim women healthcare professionals in Canada.

Second Stage

In the second stage, I started analyzing themes across participants' narratives. Themes that emerged in more than one participant's story were highlighted. Analyzing themes across narratives provided me with an opportunity to explore the similarities in the issues that participants' faced, the different ways through which they overcame the challenges, and various meanings they attached to their experiences. Specifically, the critical theory approach enabled me as a researcher to analyze the transcripts with the intention to look for ways that can facilitate change pertaining to healthcare organizational effectiveness, health practices, and program development policies.

Ensuring Rigor of the study

A number of strategies helped ensure the rigor of the study. I kept a journal throughout the study, as reflexive journaling is an important tool to "ensure the integrity and trustworthiness of the research process" (Finlay, 2002, p.531). For credibility, my research supervisor reviewed the stories during the analysis phase. As a result, the help of my supervisor throughout the data collection phase, analytic process, researcher reflexivity, and thick descriptions provided me with valuable insights (Morrow, 2005). This helped enhance the breadth and the depth of the data analysis process – also, the thickness of the description played a vital role in this study because it can unravel multiple layers of culture and contexts that exist within the experiences of each individual's narrative (Morrow, 2005). Further, Whittemore et al.'s (2000) primary and

secondary criteria were used to help ease the tension between creativity and rigor in narrative research (Whittemore et al., 2000). **Appendix E** outlines various quality considerations in helping create a contemporary synthesis of validity criteria for the purpose of this study (Whittemore et al., 2000).

As previously mentioned, “narrative research offers diverse ways of interpretation between the participant and researcher, as both are narrators and interpreters” (Smyth Murray, 2000, p. 328). However, taking into consideration the multiple interpretations in terms of exploring the experiences of Muslim women as healthcare professionals, I was specifically looking for the impact social inter relations and various other power dynamics have in shaping the experiences of these women. Hence, “...I take the final narrative ownership based on the grounds that as a researcher I am looking for vivid exemplifications of theoretically significant social categories” (Smyth & Murray, 2000, p.328).

Ethical considerations

Given the vulnerable nature of this population, due to the current condition of Muslims in the West, especially the September 11 incident, certain ethical concerns apply. For instance, it raises the issue of confidentiality – are the Muslim women recognizable because of their narratives? “The danger of identification carries with it the associated risk of sanctions, stigma, prejudice, and reprisal to the participant or their wider social group” (Hewitt, 2007. p.1154). As a researcher, I did not want them to feel vulnerable if they discussed any form of prejudice they may have suffered in the past. The goal of most qualitative research is to delve deeper into the experiences of its participants’ throughout the interview process.

The qualitative interview is often designed to be probing in nature as it aims to gain access to deeper levels of understanding of the reasons and context for participants' beliefs and actions. Anxiety, distress, guilt, and damage to participants' self-esteem might have occurred as a result of exploitation through the overly intrusive interview. (Hewitt, 2007, p.1153)

Second, did this interview make them vulnerable in the Muslim community, or their workplace? For instance, it could be painful for them to talk about their experiences at some point. The interview process therefore could have been a source of discomfort as the participants' might share painful experiences that they didn't intend to reveal (Hewitt, 2007). In order to address these concerns with the participants, on-going informal consent and debriefing were done to ensure participants' identities are protected and to prevent them from any potential harm.

Another important ethical consideration taken into account was during the data analysis phase. According to Smyth & Murray (2000), "one of the key ethical issues in narrative research arises during the analysis and interpretation phase, because this is the phase in which multiplicity of narrative meanings becomes evident" (p.331-2). One of the strategies adopted to maintain the authenticity of the narratives was through reflexivity. Hence,

In order to ensure the autonomy, dignity, and privacy of research participants, more emphasis was placed on reflexive research process by performing ongoing critical scrutiny and interpretation, not just in relation to the research methods and the data but also to the researcher, participants, and the research context. (Gillam & Guillemin, 2004, p.275)

Since participants retained the right to withdraw themselves, and their data, from a study at any time, debriefing was done for participants in the form of an informal conversation to discuss what had taken place in the session, and any potential vulnerabilities or concerns they may have had to ensure confirmability before “analyzing personal data about their life experiences” (Coates & Howell, 1997, p.114). Participants were asked to review the documents and provide feedback on the content of their stories.

To summarize, this chapter provided the rationale for choosing the critical narrative inquiry approach to explore the experiences of Muslim women as healthcare professionals in Canada. I then discussed in detail the research sample, data collection methods, data analysis, and strategies to ensure rigor.

CHAPTER FOUR

Unique themes present in the Stories

In this chapter I present the unique themes according to the stories that were constructed during the first stage of the analysis. These aspects were brought into light by the participants in a rather unique way, and that is why I made the decision to convey it within the individual stories.

Throughout the presentation of the stories as well as in the interpretation section of this thesis, italics will be used to highlight the direct quotes from the participants, so that the reader can differentiate the researcher's voice from the participant's voice. The quotes from the stories have helped add authenticity to the individual stories. The purpose of presenting the stories of these participants is to demonstrate the depth and richness of each participant's experience. In order to protect the participants' anonymity, some dates, locations, and names are purposefully disguised or omitted

Nadia's Story

Nadia is in her early 30s from the Middle East. While living in the Middle East, Nadia realized she was facing a few obstacles that interfered with her progress as a medical doctor. For instance, in the Arab culture Nadia faced some barriers such as the lack of freedom to express her opinions, and the difference in the ways women are treated from men, which restricted her growth as a healthcare professional. In order to further advance her career in medicine, Nadia decided to come to Canada as an international

trainee, where she believed she would get more opportunities in terms of knowledge, education and all other aspects of the medical field.

After coming to Canada, Nadia went through many positive developments in her life, because she felt significantly freer to express her opinions, and gained a lot more confidence, which vastly improved her communication and interpersonal skills. For instance, before coming to Canada, Nadia said, *“I used to be shy, not able to express whatever I wanted to say...here I learned to be more outspoken”*. Nadia expressed a positive change in her personality when she said, *“I learned how to communicate with people, with patients with different cultures, you know different religions”*. Although she was happy with the positive changes that took place in her life, Nadia mentioned that she had to go through some struggles in order to adjust to the cultural differences and establish herself as a successful non-Canadian Muslim female physician working for a health care organization in Ontario. Throughout her story it is possible to see the changes Nadia underwent in order to adapt to the new environment.

Despite facing some criticism, specifically from patients and people under her authority such as the nurses, she found herself to be in a place that allowed her to grow as a true professional. Nadia really enjoyed being part of a dynamic healthcare team in Canada which also gave her an opportunity to tap into her leadership skills, where she was the primary decision-maker in some cases while doing her residency training.

Limited freedom in the Arab culture

Nadia described how there is limited freedom for women in the Arab culture. For instance, women in the Arab culture are subjected to different standards compared to men. Nadia elaborated, *“like, you know in our culture women are treated in a different*

way. *For example, others always respect that she is shy, modest and polite. But here I think everyone is treated the same*". Nadia felt that women in Canada were treated equally and had far more opportunities than women in the Arab culture because there, they were expected to adhere to certain standards and restrictions that were imposed on Muslim women which were primarily derived from the cultural values and norms. For instance, Nadia wanted to present the true image of women's role in Islam when she said, *"...be the best example of Muslim women who are career-oriented... and that is one of my objectives is to try to express and tell people how Islam looks like and what role women have in Islam"*. She further shared her understanding of Islamic beliefs when she said, *"for example, we are not oppressed and we are given freedom to make choices. And I hold onto these values and wanted to present that"*. Hence, Nadia wanted to expand her learning horizons because she described, *"here I learned...not to be shy of asking any question, there is no question that is a silly question - and this is what I have been told"*. Before coming to Canada, Nadia did not feel free to openly express her opinions in the workplace, she explained, *"as I said you know in our culture women are usually shy, cannot talk, and can not speak loudly with confidence. That was a huge obstacle in my life and I actually broke this obstacle, I got over it"*.

Experiencing struggle to establish herself as a physician in Canada

When Nadia moved to Canada to do her medical training she found herself in a different medical environment than what she experienced back home. Nadia felt that her personality went through a lot of positive changes, like she felt freer in being able to do what she wanted to accomplish and was able to express herself more openly. Although

Nadia was happy to experience the positive growth in her life, she expressed that she was a little nervous before coming to Canada. She explained:

My biggest concern was that I am going to face discrimination given my religion, my appearance with hijab, umm but I did not find that. I am so happy that I did not find it, I did not see it. I think people here got used to training multicultural students and residents.

For instance, Nadia reported that she received positive comments about her hijab, she said, “...they always commented on my hijab saying it is nice or it is bright...so they are always commenting in a friendly, positive way to my hijab”. She felt that although people did question her as to why she wore the hijab, but when she explained, “...it is part of Islamic instruction and code of modesty. So they respect it”.

Nadia expressed the elation she felt when she was being treated the same way as other medical residents. When Nadia started working here in Canada, she was a little apprehensive, she said, “I expected that they would look at me as if I was a weird person, but I did not. It was fine. I was treated the same way Canadians were”. She found out that the reason she was treated the same way as other residents had more to do with the wealth of knowledge she came with, she expressed:

I think what matters is you know your knowledge, like I came with a good knowledge background and that's what helped me. I think if I were weaker in my knowledge...I would have suffered a little bit. So I think what helped me here to progress in this program is my knowledge.

Hence, according to Nadia, there was, “...no differentiation between men or women, or a Muslim woman with a headscarf”.

However, Nadia had to face some challenges in adapting to the new environment such as learning to communicate in English. She explained, *“there were many barriers including language barriers... But luckily enough, Alhumdulilah (by the Grace of God), my language was not that bad and it was not that great, you know. But with time it improved”*. Nadia again emphasized that any barrier could be overcome if a person had a good knowledge background, she said, *“...and my knowledge actually made a difference, like you know umm in the medical field, if you are knowledgeable, no matter what your language is like, you are going to be fine”*.

In addition to the language barriers, Nadia also encountered some problems in her work environment where she felt she had to work a little harder to prove herself. Nadia described how initially she had to face some tough situations with people who were working under her authority such as the nurses who she felt wanted to *“irritate her”*. She expressed:

I think they had problems being you know...umm non-Canadian physician giving them orders, you know that was hard somehow on some people. I found some difficult nurses umm you know like I had trouble with them, like when I would give them orders to do, they would argue with me sometime you know and umm... and pretend they know and I do not know anything, something like that.

Nadia encountered some challenging situations with the patients during her practice where she felt she was being judged because of her Islamic values. She described:

I met this Jewish lady with her husband. She was in emergency, I went, I said hi and introduced myself and I started asking questions because I wanted to take

history and examine her. She was looking at me in a very angry way and she told me literally, 'Get out of here'.

Nadia further explained that later the Jewish lady's husband approached Nadia, identified himself as a Jewish man and apologized to her for his wife's behavior. She stated that she understood the lady was under intense pressure and she declared she did not have bad feelings about that situation.

Nadia described how she handled hostile responses from patients or nurses in a professional manner, she said, "*so I was very professional in giving them the orders and explain it to them, like not only order but also try to explain it to them why am I doing this and so forth and so on*". The challenges Nadia faced did not deter her from the main goal, as she still managed to remain focused on excelling in her career rather than getting bogged down by the negative reaction of people, when she noticed, "*they would look at you as if they do not believe you are a doctor*". Nadia strongly believed that your knowledge and work performance should speak for you.

Overcoming challenges in the healthcare environment

Going through struggles in order to establish herself as a physician in Canada provided Nadia with the ability to navigate through the challenges in the work environment as a true professional. Nadia expressed, "*well they look at you as if that they do not believe you are a doctor. Maybe because I look young too. I finished my medical school and immediately came to Canada and didn't waste time in Saudi*". Nadia further described that at times people were not sure if she was capable of handling medical cases. She said:

Some of them were even telling me: - you were too young to be a doctor - and

some of them were looking at me as if they were questioning my ability, but I tried to ignore them and I can tell from their looking, their look as if they are not really 100% sure if I am capable.

Nadia mentioned how it did take her some time to establish herself and overcome these challenges, but now she looked back at those incidents as stepping-stones toward the path of success. For instance, now patients specifically asked for her care, she said, *“when they come to the clinic they ask about me. They ask specifically we need to see Dr. Nadia. So I feel happy about this positive change. Like I never thought I am going to be in this position”*.

After Nadia gained a meaningful position among her colleagues and patients, it improved her dedication and motivated her to maintain it. According to Nadia, the struggle she went through to prove herself was well recognized, she described, *“...initially they would treat you like anyone else, but once they know you are a good trainee, they would love you. Especially in the medical field, it is your work that speaks for you more than anything else”*. Also Nadia talked about how over the years her relationship with the nurses had taken a turn for the positive, once they realized how efficient and dedicated she was towards her work. She expressed:

Even like I can tell I am senior now, it took me a while to get through this, even with nurses to trust me to like me, until they know you. So now nurses really like me because I finish the work quickly, even quicker than the consultants. So they are happy, always looking for me to help them finish their clinic (smiles).

Nadia also felt the healthcare organization in Canada tremendously helped her in providing her with the advancement opportunities that allowed her to realize her personal

as well as professional potential without compromising her Islamic beliefs. For instance, she did not feel her values and traditions interfered with her work performance, when she said, “...for the Friday prayers you know we are allowed to go without any problem and the same thing with the Islamic festival Eid. They would give us time off”. During her residency training Nadia did not feel finding accommodation for prayer was difficult in the hospital, she described, “I can pray anywhere, there are many call rooms that are empty during the day”. Nadia believed that if you had the intention to do something, then it would become easier for you to find time for it, when she said:

There is always time to pray, no matter how busy we are. Even if we are really busy, I would just go tell my staff I have to go pray for ten minutes, he would say absolutely. Never give you any look.

In terms of fasting in the month of Ramadan, Nadia noticed that her colleagues would “appreciate” that she is fasting. She mentioned:

They would understand and they are really polite, like they try not to eat in front of you. And residents would apologize if they were eating, because we have teaching every day and there is food every time. So they would say we are sorry. I told them, do not say sorry, I am used to this (smiles).

The decision to come to Canada enhanced Nadia’s overall lifestyle, she felt that in the Middle East she was not used to interacting with people and did not have much confidence in being a team leader. However, Nadia believed that Canada allowed her to tap into this aspect of her personality. She explained:

So now I can talk to whomever without any fear. I am able to teach – like this was maybe you know one of the impossible things that I would be able to do because I

was really shy of talking to others, imagine I am going to teach. Now I am able to teach with all confidence and I feel happy about it. I can even argue with consultants on patient management in a polite way and they would accept it you know.

She further elaborated on the positive changes she went through, when she said, “for example, even the medical students they are very open and would love you. Like they would never judge me based on the headscarf”. For instance, Nadia fondly recalled her experience when she had to play the role of a team leader and how it helped boost her confidence immensely, she described her role as a primary decision-maker, when she was a senior resident and running the show. She said:

I was worried because I was the primary decision maker in the team....so I make decisions all the time...so basically everyone comes back to me and not the consultants....so I felt good about this that you know they are coming back to me, they are trusting me.

For Nadia, the opportunities that were provided to her to enhance her personality and career also provided her with a sense of self-worth and an increase in the level of acceptance from the Canadian community. For instance, she talked about the support she got from the consultants that made her feel more accepted. She described:

For example, if I plan to do something on a patient, even if they think I maybe somehow wrong, they would still say let us just do this and see what happens, let us try it, or I agree with you although I would rather do this, but you know what let us just try your way. So they would try not to change your plan.

Nadia also discussed the importance of the leadership role she played in medical

teams and how the positive response that she got from the team members tremendously boosted her self-confidence. She expressed, *“and they really liked me because I was not just telling them to focus on work, but also focus on getting educated as well, like learn and gain more knowledge”*. According to Nadia, the opportunity to be a team leader helped her tap into her hidden potential, she said, *“...I got that wonderful opportunity to be a team leader. So I see that as a quite an achievement especially for me as a Muslim woman. That was the best period in my life”*.

Nadia concluded the interview talking about how she noticed a rise in the level of acceptance towards the Muslim women in her organization, she said, *“...like if you come here, you will see more Muslim women accepted than men in every program, every specialty there are at least three or four Muslim women”*.

Sama's story

Sama was born and raised in South Asia, where she finished her medical education before moving to Canada. After she moved to Canada, she started to prepare for the exams to get into the Canadian healthcare organization. Once she started her residency training in one of the teaching hospitals in Ontario, she had to face some struggles in adapting to the new cultural environment. Sama's experiences as an immigrant Medical graduate in her mid-30s were characterized by the challenges she

faced as a Muslim woman and the differences in work ethics in the Canadian society compared to what she experienced back home in South Asia.

Importance of Islamic faith

Sama felt her Islamic faith and traditional beliefs provided her with a sense of identity that she was missing after she moved to Canada. Before moving to Canada, Sama used to not wear the hijab because she felt everyone back home in South Asia knew that she was a Muslim, as the majority of people back home belonged to an Islamic background. However, once she moved to Canada, she began to realize that since she did not wear the hijab she was not recognized as a Muslim woman, and hence, experienced a lack of sense of identity in her workplace. She explained, *“we were like a little bit different, like we did not fit with the Muslims and nor did we fit well with the western people, so we were like in between”*. However, once the woman identified herself with the hijab, it would begin to change people's perceptions of you. But for Sama, it provided her with a sense of belonging/identity that she was missing in her life.

Prior to wearing the hijab, Sama described that she felt, *“like an outcast within the Muslim community here in the hospital”*. She further expressed, *“you have a sense of identity now like you are not in between, like before I was confused between Muslim community and western people”*. The decision to wear the hijab for Sama helped shape her experience in a rather positive way. She described, *“and after veiling I didn't find any difference, like attitudes toward me, also I think it actually kind of improved”*. For instance, it helped her blend in more comfortably with her Muslim colleagues, she said, *“Muslims who work here became more receptive to me”*.

Sama argued that despite how much a person would try to change themselves and imitate the West, the difference would still remain the same, she said, *“we can never be like Western people, we always will be different no matter how hard we try to fit in or wear western clothes, we will still not be like them”*. After having this realization, Sama felt the need to be identified as a Muslim woman by wearing the hijab. She explained:

So, after covering they at least know that I am different; I would not drink alcohol or mingle freely with men. So that's why it is more comfortable saying no to such kind of things rather than you have to explain, like before I had to tell them even though I do not wear hijab, but I still do not drink alcohol.

She further found out that wearing the hijab was a blessing that helped create more opportunities for her, she described, *“I am surprised because girls who are wearing hijab are getting more residency spots. I do not know, maybe God helps create more opportunities for you because you are obeying his command like you wear the hijab”*.

Sama also noticed that since so many women in hijab were getting into the Canadian system, it helped create cultural safety in the workplace, in the sense that she was able to practice her Islamic faith freely, she said, *“...I did not find very many negative experiences here, plus there are too many Muslims already working here in this hospital, so maybe that's why since everyone is used to”*.

Sama consistently demonstrated that her values and Islamic traditions had always been of utmost importance to her. She believed in demonstrating to people through her actions that the role of women in Islam was in no way restrictive or made her feel oppressed. Sama believed that the Islamic traditional values did not interfere with her clinical practice because, *“medical profession in Islam was highly looked upon”* and a

doctor was seen as a healer regardless of the fact if they are a male or a female. She further described, *“I do not think there is anything bad written about a Muslim woman doctor touching a naked man as her patient, so from a religious point of view it is seen as a part of my job as the healer”*.

When she moved to Canada and started working she wanted to project the same image of a Muslim woman by continuing to practice Islamic values and also by making sure that, through her actions, she could demonstrate that her religion did not limit her growth or progress as a healthcare professional in any way. Sama found out that having a strong faith in God helped her cope with difficult situations in the medical field, for instance, she described, *“obviously we believe in Allah, that there is one God. So I think with everything you can only do so much and then it is up to God. So that helps sometimes”*. Sama further talked about when working as part of a team with people of different faiths, her belief system in seeing God, as the final decision-maker was something that she never openly discussed. Sama mentioned, *“actually I never discussed this out loud. This is just an inner belief or faith if you may call it which I carry with me in my practice”*. In some instance, Sama argued that, if the patient was dying and they would talk about the importance of prayer and how it could change anything, she assumed that she could better understand the importance of a prayer because of her own belief system compared to someone from the West. This perspective was evident, when she said:

Sometimes when the patient is really very sick and you are trying to do whatever you can do to save their life. But you have this inner satisfaction that you know I am not God, I cannot save this person. There is the role of prayer as well. So for

example when I tell a patient that basically you are dying, you have cancer which has spread to your whole body and there is no chance of your living. And then when the patient tells me oh no there is still someone who I can pray to. So in that case, I can understand them better because I also have a strong belief in God. You know God can do anything. I think from our religion background we can understand this faith at least and maybe Western people may not, they might say oh no no one can save you. But at least from our point of view we can say yea there might be a way and God can do anything, so one should still pray. In that sense, it helps and maybe Western people may not, they might say oh no, no one can save you.

Tensions created because of her Identity as a Muslim woman

Sama explained that at times her identity as a Muslim woman such as wearing the headscarf did pose some problems for her in the workplace: *“sometimes when they see me in a scarf they might not take me very seriously, like I could tell from their facial expressions, but they didn't say it out loud”*. But Sama also mentioned that such reactions from her patients or anyone else did not discourage her from doing her job well. She explained, *“my goal is to continue working here and help improve the image of Muslim women by being a good example and prove that headscarf or veiling is not restrictive in any sense”*. According to Sama, it was important to portray the right image of women's role in Islam through actions, she said:

I think it can not be done by saying it out loud, but by working and doing what we are doing, it does convey the message. Like it doesn't stop us from doing what we are doing by covering our heads”.

On the other hand, in some cases, Sama's identity as a Muslim healthcare professional helped some of her Muslim patients feel at ease. She described, *"so if a Muslim patient sees that a Muslim doctor is treating them they are more happy, they are more comfortable and they can discuss things related to religion more comfortably"*. Similarly, in other instances, when Sama was dealing with non-Muslim patients, she did not feel she was seen differently, she expressed, *"so I never thought that patients are looking at me thinking that I am oppressed"*.

Sama was exposed to some cultural differences that included shaking hands with the members of the opposite sex. These social practices made her feel a little awkward in the beginning because back home in professional environments men did not shake hands with women out of respect. Sama also felt that because of wearing the hijab and her other Islamic traditions she was considered as an outcast in her working environment. She explained, *"well I feel covering the head definitely plays a role in that. Like they would not share jokes with you or be very friendly like they would be with other residents"*. Sama noticed this lack of acceptance in her workplace was prominent at times when she was working as a team, she said:

For example, when you are working as a team that has one or two consultants and two or four other residents, they would be more reserved with me compared to others. Like they would crack more jokes with other residents.

She further elaborated:

Also, I do not have any friends that are non-Muslim Canadians. I just come, work, and go. Maybe, the reason is that I wear the hijab, that is why nobody is very friendly with me you know in that sense like coming to me.

According to Sama, her Islamic practices especially the hijab contributed to her being seen differently, thereby, it made her feel isolated at her workplace. She explained, *“so if I say, from that point of view then yeah it is difficult in the sense that people do not become friendly with....so I do not have any friends here, I just come work and go home, kind of thing”*.

Hence, she reported that the Islamic traditions created some tension for her in terms of the interactions with someone of the opposite gender. She described, *“one thing I would like to add with the shaking hands with the male issue. It might be something conflicting with the ethics or religion”*. Sama realized that although she was not supposed to shake hands with someone of the opposite gender, but knowing that it was a common social practice in Western environments, she found herself in an uncomfortable situation, should she choose to opt out, she explained:

Sometimes I know I should not shake hands with males who are not related to me, but because of the work conditions, I end up doing it. Since it is so common here, but sometimes I feel awkward but do not know how to say it so I just end up shaking my hands with them.

Adapting to the new cultural environment

In Sama's post-immigration experience, emphasis seemed to surface around the challenges she had to face to be recognized as a true professional in her work environment. Although Sama believed that getting into the Canadian healthcare system was something that she considered as a *“chance opportunity”* or *“God’s blessings”*, once she entered the program she knew she had to work hard enough to overcome the challenges. Learning to adjust to the new environment had its own shares of struggles

because of the way the Canadian healthcare system worked compared to what she was used to back home in South Asia.

In addition, Sama also mentioned how it took her time to adjust to the differences in the way things worked in a Canadian healthcare organization. For instance, Sama reported the differences she encountered in the Canadian workplace compared to what she was used to back home in South Asia, she expressed:

There is a quite a marked difference. In South Asia I used to work for a government hospital where we didn't have any computers or any electronic media. Things were really bad, like there was only one CT scan in the whole city.

Once she started working in Canada, she had to learn how to work with technology, she explained:

So when I came here it was totally different. Like everything is computerized, you can order a test and it will be done in a day. And obviously it was a bit of a change for me to learn the system.

Sama described that she encountered problems especially from her staff during her transitional phase. She expressed, “*so when I used to ask them how the system works, so they would give me that surprised look! Some of them even said you should have done some clerkship before coming here as a resident*”.

Sama reflected on how her lack of training in the technical aspects such as working with the computers or using other technical equipment had a negative impact on her well-being. She described, “*I used to be depressed for that one or two months initially, thinking they would not let me finish my residency, but then I learned quickly*

and everything worked out". Sama reported that when she started her residency they did not have any pre-training programs offered to international medical graduates which made adjustment really difficult. She said:

But then next year what they started was with all the IMGs (International Medical Graduates), they gave them pre-training. They started giving them one month pre training in which they would just rotate them into different departments to get them used to rather than giving them responsibility of twenty patients on first day. Like they would just observe. So at my time it was a bit difficult, but Alhumdulilah (by the Grace of God) it is gone and I am sitting here today (smiles).

Despite all the challenges, Sama believed that her background knowledge did play an important role in helping her smooth out the technological deficiencies. She mentioned, *"but I think my knowledge was good, so they kind of ignored it for that one month and gave me another chance to work"*. Sama also described that when she realized her staff members were not very supportive in the beginning, she had to muster up the courage to voice her concerns. She expressed:

Because I voiced my concerns just after a week of working here. For example, I went to my department and told them: I am just new and I do not know how all these things work, so is there a booklet or any handbook with instructions about computer or administrative things that I can take with me? They did not have any such thing and the answer I got was "oh you should have done observe-ship. It was your fault".

Sama declared that this process was very exhausting and difficult for her as she could not find the right kind of support in the beginning to cope with the difficulties she was facing in her work environment. She elaborated:

Because I did notice there was a lack of support and understanding from people here initially. But now things are improving, and they have already done so much. But people were not that supportive, so they should focus more on educating people in that sense in order to help the barriers fall.

Other differences that Sama noted in the Canada healthcare system that she had to learn to adjust to had to do with patient consent/care. She explained:

I think patients here are more knowledgeable and the system here is such that you have to ask the patients about everything whether they would like something or not. For example, consent is very important; you can not do anything against their wish or will. This is different in back home, where if we think this is needed for the patient, we would just go ahead and tell them and they would say, yes.

Regardless of the differences, Sama felt that it is easier to overcome any challenges that you face in the Canadian healthcare environment because they would give you opportunities to prove your talent through hard work and cultivate your work career accordingly. Sama acknowledged the fact that Canadians turned out to be far more open-minded than what she had imagined before coming to Canada. She mentioned:

One good thing about the Canadians is that once they see you are hardworking and conscientious and you are doing your job properly then they really start respecting you. They would not really care whether you cover your head or you

are from a different culture. They give you, not maybe equal, but similar opportunities.

She further described the importance of cultural safety in the workplace, because she did not face any harsh reaction from her Canadian coworkers about her Islamic practices, she reported, “...*I did not find many negative experiences, plus there are too many Muslims already working here in the hospital, so maybe that is why everyone is used to*”.

Experiencing struggles because of her cultural and religious background

In addition, Sama described that her lack of language fluency and other cultural barriers also helped promote her isolation in the workplace. She explained:

It does make you feel left out. But then I am a Muslim, and second I have a language barrier to an extent and the culture barrier as well. That makes it even harder. So it is not just being Muslim or religious, it is also cultural differences. Like overall, we do not go out, we do not drink, we do not watch the same movies, or sports or TV shows. There is no common ground, right. So that is why I feel they have been quite reserved.

Sama also reflected on the behavior of her colleagues and stated that the younger colleagues compared to the older ones made her feel more of an outsider. She expressed:

I found that elderly consultants were relatively more open than the younger consultants. Like they were more friendly and nicer than the young ones. The young consultants seemed more hesitant and uncomfortable in my presence. For example, if I am alone with them, they would be more uncomfortable.

But for Sama these awkward moments were easier to ignore because she was driven by her passion for medicine and focused most of her energy in fostering her growth as a healthcare professional.

Importance of Meritocracy in the Canadian environment

Finally, Sama expressed that although she lacked the technical expertise in the beginning, she felt gratitude towards the Canadian healthcare organization for recognizing the potential in her and giving her the opportunity to prove herself through her dedication and hard work. Sama talked about her current position that once belonged to her Professor who retired. She said, *“I have the same office space that he had, and a secretary, too. I remember sitting on the other side of the desk as a student learning from him and today I am in his position”*. According to Sama’s experience, Canadians were open-minded enough to accept someone with a different background into their system, but it should be up to the individual to work hard to take advantage of the opportunity offered. She detailed:

At least they give you an option, like in my case they gave me this position for a year to see my performance, in which I have to prove myself and then they would extend it to full time position. This is something positive and we should acknowledge it and be grateful for that. For example, I have heard that in other countries even in Muslim countries, if you work hard for years, they would still not give you the same status as their own citizens or outsiders, but Canadians are really good in this regard, they give you citizenship and other opportunities.

Sheila's Story

Two major themes could be identified within Sheila's narrative of her experiences as a Muslim woman healthcare professional in Canada. Although Sheila was born in South Asia, she grew up in British Columbia where her parents moved when she was 3

years old. She finished her education in British Columbia and then moved to Ontario. Sheila and her husband both work as healthcare professionals in Ontario. Sheila's experiences while going through school in British Columbia represented the struggle she had to go through in terms of trying to assimilate herself in the Western culture while adhering to her Islamic values.

Struggling with Interwoven identities

Since the start of school life in Canada, Sheila went through the struggle that made her feel torn between two identities. For instance, at home she was inspired by her parents to practice her Islamic values which included wearing the hijab, but at the same time, she felt the desire to feel a part of the Canadian society. She could strongly identify herself as a Canadian because she was not exposed to any other culture or did not know much about life in South Asia. However, when it came to her Islamic values, she was always inspired by her parents to practice Islam, hence, she felt the need to be accepted as a Canadian Muslim among her peers at school. She explained:

My mom was very strong and well-educated too, so I think I was inspired by her.

Because when she realized her kids will be growing up in Canada, so she started learning more about Islam and she started wearing the hijab as well, because she never wore it back home in Pakistan.

In order to embrace her religious identity and be known as a Muslim, Sheila decided to wear the hijab for the first time in grade ten. She expressed, *"I think it was the first day of grade ten and somebody made a rude comment so I took it off and that was it, obviously I was not ready"*.

Sheila felt that she went through an internal struggle in order to prepare herself more strongly to be ready to accept the challenges that came with wearing the hijab: *“so I was ready again to wear it by the time I was in grade twelve, so I wore it for eight years, throughout undergraduate and then medical school”*. Sheila described that it was relatively easier for her to wear hijab during her undergraduate and graduate years in medical school compared to high school where she felt being judged and hence, took it off due to peer pressure. Sheila elaborated the reason as to why she felt more comfortable wearing hijab during her university years, because she said everyone knew her so she did not feel judged by others. However, she felt that once she started interacting more with the public e.g. by like doing clinical rotations, where she was continuously coming across new people, she felt a sense of discomfort in wearing the hijab.

The challenge to wear the hijab was further exaggerated by the time when she started doing clinical rotations during her medical school, she said:

So you are doing a different rotation every six weeks, so it will always be a new batch of people who you come across, people who didn't know you. So there was a big barrier and there was a lot of prejudice.

In addition, she expressed that wearing the hijab did affect people's perceptions of her, and how it made her feel as if she was being judged because of the way she looked or dressed. She mentioned:

I think because people would hear me talk and they would say oh you do not have an accent, and I would say well I grew up here why would I have an accent, but they would say oh you look so different and strange. So I think that's that.

All these comments made Sheila feel like an outsider in the same place she grew up. She described:

I do remember feeling alienated in some way. Even though I did not feel that in the classroom, but when you go out to the public there is a different reaction, there is a bit of a wall, a barrier between even patients and myself as a medical student wearing hijab.

Eventually, Sheila felt the challenges that came with wearing a hijab and being identified as a Muslim were too hard for her to overcome, and eventually, led her to decide to take it off. She recalled: *“I think I was stressed a lot. Because eventually that’s what led me to taking it off. And my mom was not too happy with that, but my dad said it is probably better for your psyche living in this environment”*.

Sheila felt that the internal struggle and the guilt she went through when she decided to take it off were far worse. She expressed:

Well by the time I started residency I took off my Hijab, and at that time I felt like a wimp because I felt I was catering to societal pressure. Honestly, it was a lot harder on me to take it off than it was to put it on.

She further elaborated that the pressure has not really subsided, because she mentioned:

My oldest son who is nine is now developing a strong faith by the Grace of God, and he says to me all the time why do you not wear hijab? When are you going to start wearing hijab. So talk about pressure (laughs).

However, she admitted that she appreciates this kind of pressure, which came from her children, she appreciated it and in no way found it insulting because she reported, *“I do want to bring up my children as good Muslims too. It is nice in this city,*

because it is a big community and I actually sent my kids to Islamic school”.

Her role as a Muslim woman healthcare professional

Although Sheila chose not to be identified as a Muslim outwardly, she felt a strong connection towards her religious identity inwardly and made every effort to follow her life according to the Islamic guidelines. She felt that her Islamic values played an important role in shaping her performance as a healthcare professional, as her faith in God gave her the strength to cope with difficult situations. For instance, when she encountered bad situations during her medical career, she said:

When bad things happen I have a firm belief in God that some things are meant to happen. Like bad things do happen, and it is very hard for people to face it but if you have that faith that something you do not have control over is life or death. And some people who do not have that strong faith I think will have a much hard time dealing with. I do not know that, but I presume that.

Further, Sheila felt that her Islamic knowledge had helped her in her clinical practice especially when she was dealing with Muslim patients. For instance, Sheila found herself in a position to educate pregnant Muslim women who insisted on fasting, she said, *“I know you do not have to fast in Ramadan and there is a reason for that”*. Hence, being familiar with Islamic laws provided Sheila with the opportunity to educate other Muslim women, and at the same time, having a strong faith in her Islamic beliefs gave her the inner strength that helped her cope with challenges which she encountered throughout her medical career.

Sheila also talked about some of the contradictions she faced in terms of her professional duties with religious duties. For instance, when Sheila was confronted with the issue of abortion she said:

So let us say if a woman wants to get abortion done, obviously I will not do it, because it is not something I am prepared to discuss to even give way on. But on the other hand, as a physician faced with somebody who wants one I can not give her my views. That is not professional, that is not even relevant to the equation. So I have to deal with her request in a professional manner without allowing my views to color my treatment of that patient.

From Sheila's narrative, it may be implied that she viewed her behavior as professional, because she did not impose her religious views on her patients and referred them to someone who would be well-suited to handle the case.

The issue of power and professional autonomy

Sheila described that she had to face more challenges during her training or while doing her clinical rotations, because, she said, *"I do not feel as a faculty, as a staff person it is a problem. It is different when you are a student or a resident because you do not have much power or authority"*. At times, she felt it was hard to cope with the demands of residency training along with practicing Islamic traditions. She expressed:

So as a resident, when you are doing call, fasting is particularly hard. But I think you can do anything if you have the mindset, if you have the faith to do it. Like as a resident, you would work like a dog, do all kinds of hours.

However, once Sheila started her job as a staff member, she had a lot more autonomy and freedom to make more choices. For instance, she *"started working part*

time,” and she felt she had “*the flexibility to choose her hours and could easily accommodate time and place to pray in her own office*”, when she said, “*like I have my own office now*”. But, when she was a medical student, it was a lot harder, she expressed, “*as a medical student, it was a bit more difficult to find a place to pray, for sure and you might feel a little bit embarrassed because there is no place*”.

Sheila also discussed her educational experience and how it gave her the opportunity to speak out for change with regards to the issue of same-sex care requests by Muslim women. She said:

Before coming here, I actually did a masters in bioethics through Uof T so I am very involved in ethics as well. One of my projects during masters was to look at same sex care requests. Not necessarily Muslims all the time, but a lot of women who only request to have a female health care provider, which is really not looked upon favorably in this field. So I wrote a paper on that because I felt that it was a reasonable request, but it is something we can not always cater to because of the on-call care system and all.

Sheila further discussed in detail the negative reactions she noticed from the female caregivers’ perspective when she said:

I felt there was almost a hostile response from the care providers. Like males or females non-Muslim providers did not like this request. They felt almost offended by that. Actually when I wrote the paper, I found it very odd as to why women minded it more. And that’s the thing for me, people here do not understand where the request is coming from. Not just for women, but for Muslim women in particular there was a hostile response. Like a lot of people said that to me, why

do they feel they deserve to have that, because they would not have this privilege in their own country? Like why do they come here and request a female care giver, when they do not even have that necessarily in their own country.

However, Sheila argued, *“it is a reasonable request and all they have to do is respect the request...instead of abruptly saying no and feeling offended”*.

Sheila was under the impression that the issue of same-sex caregiver has not changed much over the years, she described:

I think it is a matter of education. So the really educated Muslim women, although they would prefer to have a female caregiver but they know that in the end it doesn't matter. What you want is a healthy delivery and a healthy baby.

Sheila felt that by educating people in terms of the limitations of the on-call system here in Canada and how it depends on the availability of the physician, could help smooth out the differences, as it would make them feel respected. She said, *“...just put it in a polite way that ‘I would love to deliver you, but that is how the call system here works’...instead of abruptly saying no and feeling offended”*. According to Sheila, the Muslim women would understand their reasoning as long as it could be handled in a sensitive manner.

Regardless of the differences or some challenges Sheila encountered, she talked about the changing tides now, when she said:

I think now there are good opportunities available for Muslim women here. Like I noticed that the national society of obstetricians has a poster they put up and it has a picture of Muslim women in there as well, which really pleased me.

Sheila further described how the social change and level of tolerance was rising within the health care contexts, when she emphasized the cultural safety in her workplace, she said:

Also in terms of people's questions or comments about these things: when I am frank with people or they know me I am very open about things, even the nurses in the hospital, if I feel comfortable with them I would feel very free in talking about religion and things like that.

Zoya's Story

Zoya was born and raised in South Asia where she finished her medical education. Right after she was done with school in South Asia she got married and moved

to Canada. Zoya always felt that although her career aspirations were really important to her, but she also felt a strong desire to make sure she is fulfilling all her responsibilities as a mother. Zoya considered parenting as her utmost priority which triggered her to sacrifice aiming for a more ambitious specialty in medicine. Hence, the increased responsibilities in Zoya's life, such as starting her own family and the demands of a competitive field led her to compromise her primary ambitions. Although Zoya did not wear the hijab, she talked about the importance of Islamic values in her life and the tensions she encountered between Islamic traditions and Western medicine during her practice. For instance, in some cases, her religion was guiding her towards one direction, but on the other hand, the experience she had gained from the medical field would direct her to a different path. Hence, learning to navigate through the differences that arose in situations like abortion or other ethical issues turned out to be a new learning experience for her.

The essence of Zoya's immigration journey was reflected in her initial work experiences during the residency training; coupled with her struggle in developing a sense of belonging during the residency training; the transition from her residency into establishing her own practice; and tensions between work responsibilities and family obligation

Initial work experience throughout the residency training

Going through the struggle of getting into the residency training

Although Zoya had to write the exams in order to get into the Canadian healthcare system, she still recalled the experience as a positive one and considered herself very lucky compared to her friends who had to struggle for years in order to get into the system.

She expressed:

It is very very very competitive. But I was lucky when I came I was a fresh graduate, just finished off my medical school, I did not have any responsibilities such as family and kids, I was married but did not have any children at that point. So it was easier for me to focus on studying and get managed to get into the system within one and a half-year. But I know many physicians who have been struggling for many years like say ten years or so and they just can not get into the system. So it is very very competitive.

Zoya was selected out of the top two hundred applicants out of the thousand applications. In addition, she was chosen as the top fifty applicants based on her highest scores which allowed to her to get into the system through direct entry that basically exempted her from doing the nine months unpaid clerkship. The reason Zoya got into the system so early and that too was among the top fifty candidates made her feel extremely blessed.

Although Zoya was pre-selected, she still had to go through the interview process, which turned out to be a challenging experience for her, even though she was not worried about being rejected an offer as she had to just decide which university program she would choose for herself. For instance, Zoya mentioned:

I also noted that candidates who had an accent or had trouble with language communication that kind of acted like a barrier for their acceptance. So I felt at some point you were being judged because of the lack of language fluency.

Zoya also talked about how she noticed that some of her friends who wore the hijab had a much harder time getting into the Canadian healthcare system.

Zoya finally chose her specialization with less hectic lifestyle, compared to other specialties in the field of medicine because of her family obligations. She felt that since she was starting her own family and just had a baby girl right before starting her residency training, she did not want to opt for a busier lifestyle, she mentioned:

I did limit myself...only because I was starting out my own family and I knew the hospital workload will be too much and challenging and it would be hard for me to take care of my daughter, so I had to let go of other options. But it's okay.

Entering the residency training program

When Zoya first started her residency training, initially, she only remembered it as a positive experience where her supervisor and staff turned out to be very supportive and understanding. Although Zoya got into the system through direct entry, she felt that it is what made her feel very anxious compared to the candidates who went through the nine months unpaid rotation. For Zoya, getting into the system seemed relatively straight forward, but because of her lack of exposure to computer technology and Canadian working environment, she encountered some challenges. She felt that navigating through the new system as a fresh graduate from back home was very difficult. Zoya described, “*I do not have any idea about the medications in Canada. For example, same thing but with different names than back home, it is a different prescription style*”.

Zoya mentioned that having a very understanding supervisor made it easier for her to cope with the challenges of being an international medical graduate. According to Zoya's initial impressions, it was not the interactions with the people that created problems for her, but it had more to do with her struggle to adapt to the new working environment. She expressed, *"but in terms of technology I had to face some problems. I had to start on Oscar that is an electronical medical software. Like back home we are not that much computer literate over there"*. She felt that learning to accustom herself to the new system had become a lot more difficult because of her lack of computer skills, for instance, she described:

I think I created my email account when I was done medical school. And my brother did it for me; it used to be like that. And I did not know how to check my email when I got married. And imagine that person coming in and starting on electronical medical software, that was the challenge.

In order to better understand the software, Zoya recalled that she asked her supervisor for help and felt a little embarrassed when her supervisor came to know that she was quite computer naïve. She expressed:

So I sat down with my supervisor and told him that I am very computer naïve and if you could please sit down with me and teach me. And he did not realize how I would say backward or naïve I was like he thought I would know some bits of it, right.

In the beginning, Zoya felt that her lack of computer literacy made her rather less competent compared to other residents, as she felt, *"other residents would spend more time with the patient, I would spend enough time with the patients as well but it took me*

longer to complete my notes and I would read more and have typos and what not”. Zoya recalled her experience when she had to do a project presentation; she learned to navigate through the challenge of doing the project presentation by getting help from someone who would be willing to take care of the computer-related research part for her. She felt that the support she got from her team mates helped her go through the presentation without any difficulties. Zoya mentioned that, although adjusting to the new environment was very challenging, it became even more difficult to cope with the challenges, if you did not have a supportive staff at your workplace. She expressed:

I have heard from other residents in different places and their experiences have been horrible while going through the system. Some of them had really bad experiences, some of them were kicked out of probation period just because of you know. But thank God my experience was not bad at all.

Zoya found out that learning to adjust to the new environment was an ongoing experience in the first few months, because in the earlier part of her training she had to go through different specialties in different hospitals. So for her it was not only about getting accustomed to the learning environment of one hospital where she started working, but being able to adapt to the different environments of each and every hospital where she did her rotation, which turned out to be very challenging. She elaborated:

And then going through the different specialties, like I started off with family medicine, but then you are supposed to rotate, right like you go through emergency, internal medicine, gynecology. And you go to each hospital and they have their own software so you need to learn that a little bit because you have to access patient reports and investigations and all that.

Furthermore, Zoya felt commuting to work and learning how to drive was another challenge that she had to overcome. She mentioned, *“so when I came to Canada, I wasn’t driving back home like the majority of eighteen year olds here will be having their license and be driving”*. Zoya reported that in the early 2000s, when she started her residency, GPS was not something very common, so she had to rely on Google maps to go from one hospital to another. She described, *“first time when I went to meet my supervisor few days before my residency program started, I was lost on the road for three and a half hours. I had no clue where to go”*. Driving to new places for every academic session or seminars in different places turned out to be very challenging and stressed her out far more than the actual work throughout her training period. For instance, other candidates who had already gone through the clerkship period were very familiar with the places, directions, and knew how to navigate through other guidelines of each hospital. On the other hand, Zoya had to learn everything from the beginning of her residency period. Zoya felt that residency training program is something that should just help you gain more knowledge about your specific field and if you have gone through the clerkship rotation you would be somewhat starting on the same page as other Canadian residents. However, being an international graduate and coming through direct entry because of her top scores created more hurdles for her in terms of learning to adapt to the new system of the Canadian workplace environment.

In addition, Zoya felt that being an immigrant also created some communication barriers. For instance, the city where her hospital was located had a predominantly white community. According to Zoya, it seemed harder for the population there, as they were mostly white Canadians to accept service from a non-white resident. She expressed that

most of the patients during her residency training would not prefer a non-white doctor, she described, “*older patients, more white population and they would like to see a white doctor. They are not necessarily welcoming to any South Asian physician*”. The second time around when the lady came back to Zoya, she refused to give her medication because she felt it was not going to help her, however, she recalled the elderly patient not being satisfied with the response. Zoya expressed:

And she was quite upset and she was blaming the way we have been taught medicine back home. She was like you guys do not understand the Canadian system and how it works here. And you know at that point you have to just calm them down and I know it does not seem nice at that point, but she was frustrated that is why she was angry.

During her residency whenever she had to deal with challenging cases like that of the elderly patient mentioned above, the fact that she was monitored through cameras in the room helped her tremendously because that way she could get feedback from her supervisor based on her exact performance. She described:

But my supervisor knew about this, good thing we are monitored there. So there was a camera that my supervisor was monitoring. That was one of my cases that I dealt with and they watch you as how you handle difficult situations.

Despite the challenges Zoya encountered in adapting to the changes, she still felt because she started off her career in Canada at a relatively earlier age, as she was a fresh graduate, thereby her willingness to learn new things made the transition much easier. She elaborated, “*but I think it will be more difficult for people who come at an older age who have learned enough that they think they know almost everything and they are not*

ready to change or adapt you know". Zoya further expressed that despite some challenges which emerged due to her own lack of exposure to the new system, she still had a very positive experience compared to her other friends who wore the hijab. She described:

But I have seen some of my friends now, like I do not wear a headscarf but my friends who did hijab they went through the interviews and for years and years they could not get selected. So at some point they were talking about maybe it was your hijab or your cultural background or religion you know doing it.

Struggle to develop a sense of belonging during her residency training

During her residency training Zoya lacked that sense of belonging to the point where she felt like an outsider. The fact that she did not grow up in Canada and was raised in a completely different environment contributed to her feeling alienated at her workplace. She described, *"like they would talk about some TV programs or sports and what not and I would be totally naïve to that. I would just sit quietly and not sure what to do"*. Zoya felt that growing up in the cultural environment of South Asia made her an introverted person, as she used to feel very reserved with others. She said:

I think it got even more exaggerated with the fact I was mostly around the people who did not know me. Because introverted people are more comfortable with the people they know. They tend to not open up too much. So I realized it was not that easy interacting with them at all.

In addition, Zoya sometimes assumed that Canadian residents would treat her differently, she mentioned, *"well people from here the Canadian residents they always have that in their mind that maybe we are not smart enough to be in the system."*

Sometimes they would be a little more judgmental". Since the vibe she got from her colleagues was not very inviting, she began to feel isolated at her workplace. She expressed:

For example, they would talk about stuff and umm like talk about guidelines and would totally ignore me thinking that I probably have not even heard about that and you would not know. But going through the examination process we learn absolutely everything otherwise they never select you.

For Zoya, the interactions she had with the Canadian residents within the academic environment led her to isolate herself to the point where she did not have any interaction with them outside of her workplace. She described:

As much as I can recall I did not socialize much which now I feel because maybe I was so new. Residents use to socialize a lot over there. I was very strictly very very academic. I would finish my work do everything I am supposed to do and leave on time.

Although Zoya was very much focused on excelling in her work environment, she did feel that because of the fact she was seen as an outsider affected her emotionally. She expressed, *"in the beginning I would come home and would be so stressed and would literally cry to my husband. I feel alienated I do not have any friends, I do not know anybody and you know I am very overwhelmed"*.

Zoya's transitional experience from the training period into her established practice

For Zoya the transition from doing her residency training to establishing her practice in Ontario was a rather smooth changeover. She described, *"I started off my*

practice in Toronto and I was bombarded with patients. So the doctor from which ever cultural background you are, you just open your practice and your patients will find you". She further elaborated that being a South Asian female doctor in Ontario, instilled the belief in her that it is her obligation to provide service to people with a South Asian background, she expressed:

Because I am multilingual and can speak certain languages which some people can not and I can communicate with them and understand them well and they can tell me their problems better I feel I am obliged to provide them with my service. So majority of my patient population is South Asian. Majority of them is female because I am a female so they are more comfortable which is very understandable because my own family doctor is a female and even I would prefer to have it that way.

Zoya felt that all that hard work she did over the years paid off, because now she could enjoy working in a more relaxed environment where she had the freedom to make her own decisions. She expressed:

Now it is my own clinic I prefer to work as much as I can because I have my own full time practice. But very much relaxed. I am literally five minutes' drive from my home and it used to be an hour or one and a half hour drive before. So life is better now for sure.

Despite the challenges Zoya encountered in the beginning with regards to starting her own practice, she still felt that it was much less stressful than going through the residency period. She described:

Starting my practice was stressful too but not as stressful as starting my training period. Stressful in the sense that I was still new to the system, I barely had my own family physician by the time I got my own residency.

Role of Islamic traditions in Zoya's practice

Zoya reported that it was rather easier to balance her Islamic duties with her work obligations especially when it was about praying during her work hours. She elaborated:

If I am in the middle of something, let us say I am doing a surgical procedure and say the patient is bleeding and I am in the middle of it, I will never leave her. So in those cases, I will wait until it is done, and then go pray.

In terms of praying, there was enough flexibility for her to readjust her timings and did not create any problems for her. However, with regards to fasting during the month of Ramadan, she had a hard time dealing with it, she described, “*but fasting I would say, no matter what people would say I do find that it does affect your ability, the concentration level is not the same*”. In order to better cope with working conditions during fasting, she would reschedule her office timings. She expressed, “*I did cut short on my clinic hours and start late and finish up early and go home and take a nap just before the breaking of fast time. So it does affect performance a bit*”. Having her own practice gave Zoya the flexibility to reschedule her clinic hours in order to balance out her work obligations with her Islamic duties.

Importance of ethics in Zoya's practice

Currently, Zoya has her own full-time practice with more than five years of work experience. However, when she was just starting out her own practice, she had to

learn different ways successfully establish herself and had to go through the struggle to choose new patients and build a good rapport with them. At times, she felt this posed some problems for her, since she would have patients of different ethnicities and cultural background who lived very far from her clinic coming to her for service, especially with regards to the cases of drug abusers. She described:

Also for drug abusers, I think they would prefer to come to someone who is new to the system or has not been here much. So when I started my practice here I would have patients coming from Guelph and Kitchener to come in for their narcotic prescription.

This created much confusion in Zoya's mind because she described, *"I would be very surprised and think why would you come all the way and they would say 'oh because my doctor is on vacation', but there are tons of doctors in between Guelph and GTA so why me?"* Upon doing further research as to why would someone from so far away come to her she learned that:

They would choose from the listing the new fresh graduates who are coming out and where they are practicing. And if it happens to be someone who is not pure Canadian or South Asian, so because of the background they would not know the ethical issues that much so we would buy into whatever they are saying and give them what they want.

However, Zoya reported that she still felt she was well-informed about the Canadian healthcare policies and ethical protocols, because she had to know them very well in order to pass the examination. For instance, in terms of medical history and privacy, Zoya learned a lot about Canadian stance on such ethical issues. She described, *"back home if*

my mom would come and ask the doctor to give her my entire medical history and they will give it to her”. In addition, she said:

You can give birth control to a seventeen year old without talking to the mother and I was surprised at that, because back home we cannot do this. For us it was like learning a new thing, so you learn a lot while going through the exams.

Hence, she felt that learning these ethical issues during the study period helped make her practice a lot easier. She further elaborated:

For example, the birth control one, I can tell you how many times a day I do it that I give birth control to teenagers. And oh my God, I do not know what I would have done had I not learned these things in the exams.

Moreover, in some cases Zoya found herself lecturing to the Muslim patients who came to her for abortion in order to help them better understand what’s Islamic perspective on this stance. For instance, she expressed, *“and sometimes Muslim women come to me and I do a bit of a lecture. I do give them a small speech about Islam”*. Since abortion was not reflective of Zoya’s own values, she did not feel very comfortable dealing with such cases, and hence, would handle them in a professional manner and would *“direct them to someone who would do it for them”*. Such instances would turn out to be challenging for Zoya, because in a country that follows Islamic laws, solutions to cases like birth control or abortion would already be pre-determined. But Zoya acknowledged the fact you should abide by the rules of the country where you are doing your practice, and hence, she handled delicate cases in a professional manner, even though it may be against her own beliefs.

But she further described that there was not a landmark difference between the Canadian ethics and her religious values, she expressed:

We just do what is ethical and medical system over here. But we also have our Islamic mentors here once a year and talked about everything abortion etc. And we have found our ways now, there is a mutual path that you follow your ethics and your religion as well.

Here, Zoya talked about having the importance of Islamic mentors who could help you deal with situations where you feel torn between the Islamic and the Western direction, and which path to choose.

Tensions between work responsibilities and family obligations

Zoya had a hard time adjusting to the fact that she had to leave her daughter for hours while she would be away for work. She expressed, “*like my daughter was six months old when I started. It was very difficult for me to leave her. I did not have any help at home, nobody just me and my husband who was also working full time*”. Zoya felt that had she been in South Asia, she would get help from her family in order to help her fulfill her duties as a mother and a career woman, but in Canada it was different as there was no other family member to help her around. She said:

And we have our six months old daughter who was with me the whole time and one day suddenly I have to go and then when we do our residency we are not gone for a day, but sometimes two days. I do not get back after thirty-two to thirty-four hours.

For Zoya it was not only adjusting to the Canadian work environment, but also being able to cope with the responsibilities that come with being a new mother outside of

her home country that created more tension for her. Zoya felt that her primary goal had always been to be a good mother and raise her kids to “*become better Muslims and good citizens*”. As a working mother, she is far more worried about not spending enough time with her children that could help her provide them with a more nurturing environment.

She expressed:

It is difficult to raise the kids over here especially if I am working that means I am spending less time with my kids and that is always what concerns me. That is always a worry in my mind. And that is my goal to be a good role model to my children by being a good Muslim in all aspects of my life.

The main conflict Zoya encountered between her work and family obligations was about giving enough time to her children, especially because she has her own practice now. However, Zoya indicated that her primary goal was not to cultivate her career further in medicine, but it had always been to be a good mother to her kids and fulfill all her duties in terms of upbringing her children to be good Muslims, as well as good people with strong values and morals, which she considered to be her real success.

CHAPTER FIVE

Common themes across the stories

In this chapter, the common themes across the individual narratives are explored from a critical theorist perspective. The purpose of this critical narrative study is to

examine the experiences of the Muslim women as health care professionals in Canada. The stories were analyzed through a critical lens in order to explore power dynamics that exists within different social, cultural and political contexts (Kinchloe & McLaren, 2005). Although the findings from the narratives are presented in a linear fashion, the participants' shared their stories in a non-linear fashion. As a result of the interlinked experiences across the participants' narratives, five common themes were derived.

I analyzed the participants' narratives for common themes by looking across their narratives. So any theme that emerged in more than one participant's story was highlighted. Although the findings from the narratives are presented in a linear fashion, the participants' shared their stories in a non-linear fashion. As a result of the interlinked experiences across the participants' narratives, five common themes were derived.

These are:

- 1) Importance of hijab in shaping their experiences;**
- 2) Experiencing a lack of sense of belonging;**
- 3) Gaining personal freedom through strategies of empowerment;**
- 4) Struggling with ethical contradictions between religious values and professional duties;**
- 5) The role of the Canadian society in facilitating positive change.**

1. Importance of hijab in shaping their experiences

The significance of hijab in shaping the experiences of the women in this study was characterized by the following sub-themes: helps create sense of belonging to people

with similar values; identity marker; leads to prejudice in work environment; and helps portray a positive image of women's role in Islam through role modeling.

Helps create sense of belonging to people with similar values

Women in this study felt that wearing the hijab provided them with a sense of belonging by making them feel more connected to the Muslim community at their workplace. For instance, one of the women in the study felt that while growing up in the Canadian society, she had to deal with interwoven identities and the need to find her own sense of belonging. Sheila explained:

My mom was very strong and well-educated too, so I think I was inspired by her. Because when she realized her kids will be growing up in Canada, so she started learning more about Islam and she started wearing the hijab as well, because she never wore it back home in South Asia.

Whereas, Sama realized that wearing the hijab strengthened her ties to the Muslim community at her workplace. She said, “*you have a sense of identity now like you are not in between, like before I was confused between Muslim community and western people*”. So for Sama, after she started wearing the hijab, she noticed that her Muslim colleagues became more “*receptive to her*”, which was different than what she experienced prior to wearing the hijab when she felt like an “*outcast*”. Further, Sama found out that wearing the hijab at her work helped create a sense of association not only with her Muslim co-workers, but also with some of her Muslim clients. She described, “*so if a Muslim patient sees that a Muslim doctor is treating them they are more happy, they are more comfortable and they can discuss things related to religion more comfortably*”.

Further, according to Sama, the hijab was seen as a “*blessing*” of God and a way to strengthen her relationship with God that as a result, created more “*opportunities*” for her. She said, “*I am surprised because girls who are wearing hijab are getting more residency spots. I do not know, maybe God helps create more opportunities for you because you are obeying his command like you wear the hijab*”. The participants described how wearing the hijab helped them become a better Muslim because they were adhering to the Islamic principles of modesty. For instance, Nadia mentioned that “*wearing hijab is like fulfilling the command of God*”. According to the women, the hijab was seen as a sign of obedience to their creator.

A straightforward identity marker

All the participants in this study who wore the hijab agreed that it helped define their identity in a Western environment. Although the participants felt that the hijab acted as an identity marker, they all had different motives for wearing it. For instance, according to Nadia, the decision to wear hijab was seen as a commandment of God; hence, it was not something that she can have an opinion about. She said, “*...it’s part of Islamic instruction and code of modesty*”. However, despite knowing that she was fulfilling the command of God, she still had some apprehensions before moving to Canada because she knew it was something that will make her look different from others. She described, “*my biggest concern was that I am going to face discrimination given my religion, my appearance with hijab*”. On the other hand, for Sama the precise reason that it would make her look different from others was the motivating factor in helping her choose to wear the hijab. She explained:

So, after covering they at least know that I am different; I will not drink alcohol or mingle freely with men. So that's why it is more comfortable saying no to such kind of things rather than you have to explain, like before I had to tell them even though I do not wear hijab, but I still do not drink alcohol.

In Sheila's case, her mother's struggle to instill a sense of belonging towards the Islamic faith in her children while growing up in Canada, inspired her to wear the hijab in order to embrace her identity as a Muslim. She said, *"so I was ready again to wear it by the time I was in grade twelve, so I wore it for eight years, throughout undergraduate and then medical school"*. Regardless of the underlying reasons that triggered the participants to wear the hijab, it is evident that they all perceived it as a sign of obedience to God. Hence, the participants felt the desire to portray their commitment to Islamic faith through identifying themselves as Muslims in a Western society.

Leads to prejudice in work environment

According to the participants in the study who wore the hijab, they felt that it did have some negative repercussions in terms of the way others perceived them. As Sheila explained:

So you are doing a different rotation every six weeks, so it will always be a new batch of people who you come across, people who did not know you. So there was a big barrier and there was a lot of prejudice.

This comment sheds light on the fact that although the participant went to medical school in Canada, by wearing the hijab she experienced feeling an outsider in the same place she grew up. On the other hand, Sama noticed that her appearance with the hijab made her feel less competent at her workplace. She expressed, *"sometimes when they see*

me in a scarf they might not take me very seriously, like I could tell from their facial expressions, but they didn't say it out loud”.

Another participant, Nadia felt that wearing the hijab puts her in a place which made her more susceptible to hostile comments from patients. She explained:

I met this Jewish lady with her husband. She was in emergency, I went and said hi and introduced myself and I started asking questions because I wanted to take history and examine her. She was looking at me in a very angry way and she told me literally, ‘Get out of here’.

This shows how the use of the hijab influenced participants’ perceptions of how they were perceived by others, and how it undermines their educational credibility. As an example Nadia said, “*they would look at you as if they do not believe you are a doctor*”. Although Zoya did not wear the hijab, she did describe similar challenges her physician friends who wore the hijab had to face while trying to get into the Canadian healthcare system. She explained:

But I have seen some of my friends now, like I do not wear a headscarf but my friends who did hijab they went through the interviews and for years and years they could not get selected. So at some point my friends were talking about maybe the hijab or the cultural background or religion you know the reason for their lack of acceptance into the Canadian system.

In most cases, participants felt that the hijab created some tensions in their workplace as it led to prejudice which usually stemmed from, according to them, “*ignorance*”. Since the participants found themselves in situations where they were struggling to establish themselves as professionals in Western settings, these

professionals realized that they also had to focus on finding ways to deconstruct misconceptions about the Muslim woman in hijab. The participants reported that the misconceptions in terms of people's perceptions of a woman in hijab, created a lack of acceptance or feeling of isolation at their workplace. Sheila described:

I do remember feeling alienated in some way. Even though I did not feel that in the classroom, but when you go out to the public there is a different reaction, there is a bit of a wall, a barrier between even patients and myself as a medical student wearing hijab.

The feeling of isolation was also evident in Sama's narrative. She said:

Also, I do not have any friends that are non-Muslim Canadians. I just come, work, and go. Maybe, the reason is that I wear the hijab, that is why nobody is very friendly with me you know, in that sense like coming to me.

Although unstated, the comments unravel the implicit meaning that the participants did feel that wearing the hijab gave people the impression they were strangers, which created a lack of acceptance and sense of belongingness. Hence, the hijab drew out the reaction from people that made them act more "reserved" and "not very friendly" towards the participants.

Helps portray a positive image of Muslim women through role modeling

Being identified as a Muslim by far intensified the struggling life situation of the women in this study, but it also provided them with an opportunity to depict the image of women's status in Islam by presenting themselves as educated, career-driven women.

The participants' overall experience as a woman in hijab, compelled them to find the urge to portray a positive image of a Muslim woman "not by saying it out loud" but rather

through actions. Sama described, *“my goal is to continue working here and help improve the image of Muslim women by being a good example and prove that headscarf or veiling is not restrictive in any sense”*.

Similarly, Nadia also shared the same vision of trying to portray Muslim women as independent beings who are not limited in their capabilities to excel because of hijab. Nadia said, *“for example, we are not oppressed and we are given freedom to make choices. And I hold onto these values and wanted to present that”*.

Hence, the hijab not only acted as an identity marker for the participants, but also acted as the unifying mechanism that helped them promote their vision to deconstruct social myths about people’s perception of viewing the Muslim women as *“oppressed”* and voiceless. For instance, the local Canadians would view a woman with hijab as someone who was not born here, so, it is considered very rare that some one born here would wear the hijab. It becomes a marker of foreignness. For instance, Sheila talked about her experience during clinical rotations when the patients would question her about the hijab, *“how come you do not have an accent?”*

2. Experiencing a lack of sense of belonging

The diverse experiences of the Muslim women in the Canadian healthcare environment in this study were also shaped by a lack of sense of belonging due to the differences in the cultural environment of their workplace.

The participants’ experienced constraints due to different working demands based on religious and cultural differences. The participants’ struggle to adapt to the new environment are reflected in the following sub-themes: social pressure/lack of support

from staff; prejudice; being a good Muslim caused emotional stress due to social pressure; and dealing with cultural differences

Social isolation/lack of support from staff

Although the women in the study narrated that they did not have to go through excruciating amount of difficulty in getting into the Canadian Health Care System, once they started working, they found themselves under a lot of pressure to sustain their position. Sama expressed, *“I used to be depressed for that one or two months initially, thinking they would not let me finish my residency”*.

The tension that arose due to demands of the training program coupled with lack of support from the staff increased Sama’s stress level. She described:

Because I voiced my concerns just after a week of working here.

For example, I went to my department and told them: I am just new and I do not know how all these things work, so is there a booklet or any handbook with instructions about computer or administrative things that I can take with me?

They did not have any such thing and the answer I got was ‘oh you should have done observer-ship. It was your fault’.

In order to cope with the changing work demands, the participants who were immigrants began to feel isolated in their workplace because most of their time was spent focusing on retaining their residency position. Zoya explained:

As much as I can recall I did not socialize much. Residents use to socialize a lot over there. I was very strictly very very academic I would call. I would finish my work do everything I am supposed to do and leave on time.

Both Sama and Zoya felt that the overwhelming demands of the new system further exaggerated their isolation at workplace. For instance, Sama expressed, “...*I do not have any friends here, I just come work and go home, kind of thing*”.

Another factor that heightened their social pressure was due to the technological differences between their home countries and Canada that the women faced in this study. For the immigrant Muslim women, learning to cope with the procedural technological aspects of the medical field was far more challenging than the actual scientific aspects of Medicine. Zoya expressed:

I think I created my email account when I was done medical school. And my brother did it for me; it used to be like that. And I did not know how to check my email when I got married. And imagine that person coming in and starting on electronic medical software, that was the challenge.

Adapting to the new environment was an ongoing process because of the differences participants experienced in terms of technology compared to back home, as Sama noted:

There is a quite a marked difference. In South Asia I used to work for a government hospital where we did not have any computers or any electronic media. Things were really bad, like there was only one CT scan in the whole city.

Prejudice

The women in the study reported to have faced some sort of prejudice while adjusting to the new environment because of their lack of exposure to the Canadian health care system. Sama said, “*so when I used to ask them how the system works, so they*

would give me that surprised look! Some of them even said you should have done some clerkship before coming here as a resident”.

The issue of prejudice was evident in Nadia’s narrative as well when she explained:

Some of them were even telling me: - you were too young to be a doctor - and some of them were looking at me as if they were questioning my ability, but I tried to ignore them and I can tell from their looking, their look as if they are not really hundred percent sure if I am capable.

In particular Nadia talked about her experience with the nurses where she felt she faced the most trouble. She said:

I think they had problems being you know...umm non-Canadian physician giving them orders, you know that was hard somehow on some people. I found some difficult nurses umm you know like I had trouble with them, like when I would give them orders to do, they would argue with me sometime you know and umm... and pretend they know and I do not know anything, something like that.

The above comments reflect the notion that despite being in a position of more power within the healthcare context, the participants still faced prejudice because they were perceived as outsiders.

The feeling of lack of sense of belonging that took place because of the prejudice participants’ faced was also evident in Zoya’s case, when she mentioned, “*well people from here the Canadian residents they always have that in their mind that maybe we are not smart enough to be in the system. Sometimes they would be a little more judgmental”.*

This comment further reflected her isolation at her workplace and affected her emotional

and mental well-being. She reported, *“in the beginning I would come home and would be so stressed and would literally cry to my husband. I feel alienated I do not have any friends, I do not know anybody and you know I am very overwhelmed”*.

Zoya also discussed other forms of prejudice that she faced from some of the patients who were not comfortable accepting care from her. She described:

And she was quite upset and she was blaming the way we have been taught medicine back home. She was like you guys do not understand the Canadian system and how it works here. And you know at that point you have to just calm them down and I know it does not seem nice at that point, but she was frustrated that is why she was angry.

The comments above suggest that it might be perceived that the participants in the study faced pressure in terms of adjusting to the changing demands of the workplace, and that the attitudes of the people they worked with who not think they were competent enough to practice medicine. Hence, the women were considered as outcasts. The participants who were also immigrants felt that due to the difference in their educational background they were being judged and perceived as less competent in their workplace. The issue of prejudice had significance in this study because it helped unravel the notion that cultural background more than religion, also played an important role in shaping their experiences. For instance, despite the fact that Zoya did not wear the hijab, she still faced some level of prejudice in her workplace. Hence, the issue of prejudice was a strong factor in undermining the participant's credentials and position of power that came with being a physician within a healthcare context.

Being a good Muslim caused emotional stress due to social pressure

Not only were the participants confronted with the pressure to excel in their training program to be able to integrate into the workforce, but also to remain committed to their Islamic values by being a good Muslim. In some instances, remaining true to their faith was more challenging than anticipated. For instance, Sama explained:

Sometimes I know I should not shake hands with males who are not related to me, but because of the work conditions, I end up doing it. Since it is so common here, but sometimes I feel awkward but do not know how to say it so I just end up shaking my hands with them.

Also, the issue of wearing the hijab turned out to be an exhausting experience for Sheila, because on the one hand, she felt the need to properly practice Islam, but was also faced with challenges when she was looked at differently in the same environment where she grew up. She explained:

I think because people would hear me talk and they would say oh you do not have an accent, and I would say well I grew up here why would I have an accent, but they would say oh you look so different and strange. So I think that's that.

The participants' comments demonstrate that the added pressure of being a good Muslim affected their emotional well-being because at times they felt torn between two different social norms/practices.

Dealing with cultural differences

The participants in the study felt that the differences in cultural values further created a lack of sense of belonging for them in their workplace. Sama expressed:

It does make you feel left out. But then I am a Muslim, and second I have a language barrier to an extent and the culture barrier as well. That makes it even harder. So it is not just being Muslim or religious, it is also cultural differences. Like overall, we do not go out, we do not drink, we do not watch the same movies, or sports or TV shows. There is no common ground, right. So that is why I feel they have been quite reserved.

The comment above unravels the notion that there are three layers that shape the experiences of the participants who came to Canada as international trainees or immigrants and those are: religion, culture and language. Sama felt that the lack of common ground due to varying cultural practices exaggerated the differences that exist between the Muslim women and their non-Muslim coworkers. As a result, she felt isolated at her workplace. Nadia and Zoya also talked about how language acted as a barrier because one of the ways through which you could assimilate yourself in someone's culture is through being fluent in that culture's language. Although it is not explicitly stated by the Canadians, it could be understood from the narratives that language acted as a prominent indicator of an outsider's ability to adapt to the new culture. Hence, language could play an important role in helping ease out the cultural differences.

Zoya also talked about the difficulties she faced in terms of interacting with her colleagues because of differences in cultural norms. She explained, *“like they would talk about some TV programs or sports and what not and I would be totally naïve to that. I would just sit quietly and not sure what to do”*. According to Zoya, the cultural

differences not only made her feel more isolated at her workplace since she did not have any friends, but it also made her more of an introverted person. She expressed:

Think it got even more exaggerated with that fact I was mostly around the people who did not know me. Because introverted people are more comfortable with the people they know. They tend to not open up too much. So I realized it wasn't that easy interacting with them at all.

Since these women did not share similar interests as the other Canadian residents, the participants felt people were more “*reserved*” in their presence which made them feel more of an outsider. The feeling of social isolation also negatively impacted their lifestyle, in a way that triggered them to confine themselves to only the academic aspect of their working life to the point where they did not interact with their colleagues outside of work realms, which was evident when Zoya said, “*I was strictly academic*”.

3. Gaining personal freedom through strategies of empowerment.

The participants in the study demonstrated different strategies they adopted to maintain their personal space and freedom from social pressure. As a result, these strategies enabled them to better accommodate their personal and religious obligations with their professional duties. These strategies are: flexibility in clinical practice; well-positioned status in the Canadian society; strategies adopted to overcome prejudice/pressure; and balancing Islamic practices with work obligations/family duties.

Flexibility in clinical practice

As soon as some of the participants finished their residency training, they found themselves in positions of power that allowed them to make choices to better suit their lifestyles. One of the strategies the participants adopted was to reschedule their work

hours to accommodate religious practices. For instance in the month of Ramadan, when the Muslims fast from sunrise to sunset, the women did not have the liberty to take time off during their residency training, however, once they started their own clinical practice they were able to reschedule their work demands. For instance, Zoya said, *“I did cut short on my clinic hours and start late and finish up early and go home and take a nap just before the breaking of fast time. So it does affect performance a bit”*. Sheila also started to work part-time to balance her work obligations with family/religious duties. From the women’s narratives it could be implied that the socio-economic status that they enjoyed because of a high-profile career in the field of medicine enabled them to make the decision to reduce or reschedule work hours, hence this situation is perceived to be a privilege which may not be common to Muslim women in different professions, even within the health care contexts.

Another strategy the women adopted was through choosing clients to accommodate religious values. The participants talked about some cases which they felt conflicted with their own personal values as Muslim women such as abortion. But because of the nature of their work, they were given the right to choose cases they seemed most comfortable with. For instance, Zoya expressed:

And we do have a bit of a choice here, like if someone is totally against your ethical values here, like if there is a female who comes for abortion every year, that is not a type of person I would like to have in my practice because I am not comfortable giving her advice to go for abortion every year.

Sheila also talked about how her religious values would prevent her from dealing with cases like abortion, she said, *“so let us say if a woman wants to get abortion done,*

obviously I won't do them, but it is not something I am prepared to discuss to even give way on". Although unstated, the comments above highlight the fact that the decisions these women made to withdraw from abortion cases is not only reflective of their Islamic practices, but also implies the importance of how these women justified professionalism in their practice which they used as a form of coping with difficult situations.

Canadian training provided the Women with well-positioned status in society

For the women in the study, education that came with the training opportunity they were provided with in Canada, defined their perceptions of having a high status in society. Nadia talked about her experience as a primary decision maker when she was running the show as the senior resident. She explained:

I was worried because I was the primary decision maker in the team...so I make decisions all the time...so basically everyone comes back to me and not the consultants...so I felt good about this that you know they are coming back to me, they are trusting me.

Zoya talked about the importance of personal autonomy she has now and how it has made her life a lot easier, she said, *"now it is my own clinic I prefer to work as much as I can because I have my own full time practice"*.

Sheila also shared her experience as a faculty member now, when she stated, *"I do not feel as a faculty, as a staff person it is a problem. It is different when you are a student or a resident because you do not have much power or authority"*.

Sama also talked about the importance of education and how she is today in the same position as her professor was once, when she said, *"I have the same office space*

that he had, and a secretary, too. I remember sitting on the other side of the desk as a student learning from him and today I am in his position”.

The importance of personal space was evident in Sheila’s comment when she said, *“like I have my own office now”*.

Another participant shared how her experience of Canadian education provided her with a sense of accomplishment and enhanced her personality for the better. Nadia talked about the changes she noticed in her clients, when she said, *“when they come to the clinic they ask about me. They ask specifically we need to see Dr. Nadia. So I feel happy about this positive change. Like I never thought I am going to be in this position”*.

Zoya felt that her education elevated her status within her South Asian community as well, based on the experience she had when she first started her own clinical practice. She explained, *“I started off my practice in a big city and I was bombarded with patients. So the doctor from whichever cultural background you are you just open your practice and your patients will find you”*.

The above comments highlight the fact that the Canadian education/training provided the women in this study with leadership roles, prestigious titles, high socio-economic status, and office space, which played an instrumental role in helping them feel empowered and by extension helped them to cope with the struggle they were facing to integrate.

Strategies adopted to overcome prejudice and social pressure

The participants in this study shared their experiences in terms of how they coped with difficult situations such as facing prejudice and social pressure. In the process of overcoming hardship, the women experienced resilience and strength, which helped them

feel empowered in society. Some of the strategies identified to cope with the hardships from the narratives are as follows: faith in God; overachievement; catering to societal pressure; and professionalism.

Faith in God

The women in the study talked about the importance of having a strong faith in God, especially in face of adversities as it provided them with guidance and stability. Sheila expressed, “...when bad things happen I have a firm belief in God that some things are meant to happen”. Sama also discussed how her faith in God helped her go through difficult situations. She said, “obviously we believe in Allah, that there is one God. So I think with everything you can only do so much and then it is up to God. So that helps sometimes”. Sama’s comment reveals the importance of her faith in God in her practice, but she never discussed it with her colleagues. She explained, “actually I never discussed this out loud. This is just an inner belief or faith if you may call it which I carry with me in my practice”.

Overcoming prejudice with overachievement

The women in the study described how they had to work really hard to prove themselves. According to Chang, Arkin, Leong, Chan and Leung (2004) “overachievement implies the exertion of excessive effort to reduce the chances of failure” (p.153). For instance, overcoming the pressure to finish their residency training enabled them to become far more competent than they could have imagined. The struggle they went through reflect the importance of resilience in their individual experiences. Although the women faced challenges in the work environment, by adopting overachievement as one of the strategies, they were able to strengthen their position. In

general, hard work and the need to thrive in their new environment were perceived as a way to cope with social pressure and prejudice. Nadia described:

Even like I can tell I am senior now, it took me a while to get through this, even with nurses to trust me, to like me, until they know you. So now nurses really like me because I finish the work quickly, even quicker than the consultants. So they are happy, always looking for me to help them finish their clinic (smiles).

Sama also talked about how she had to overcome the hardships by putting in extra effort, she said, *“I used to be depressed for that one or two months initially, thinking they would not let me finish my residency, but then I learned quickly and everything worked out”*.

Similarly, Zoya discussed how her experience was different than other residents since she was new to the system and had to spend more time learning how the technology worked and coping with other differences to sustain her position. She explained, *“other residents would spend more time with the patient, I would spend enough time with the patients as well but it took me longer to complete my notes and I would read more...”*

Although it took Zoya longer to finish her work than other residents she still felt that she was no less competent in terms of her knowledge about the Canadian guidelines. She expressed:

For example, they would talk about stuff and umm like talk about guidelines and would totally ignore me thinking that I probably have not even heard about that and you would not know. But going through the examination process we learn absolutely everything otherwise they never select you.

Conforming to societal pressure

One of the ways the participants felt they could better navigate through the challenges was to succumb to societal pressure. Sheila shared her experience of taking off the hijab. She described, *“I think I was stressed a lot. Because eventually that was what led me to taking it off. And my mom was not too happy with that, but my dad said it is probably better for your psyche living in this environment”*.

Although Sheila decided to take off the hijab, she recalled going through an internal struggle because she was confronted with her inner pressure and lack of support from her mother which made it a rather exhausting experience, thereby causing stress within the family context. She said:

Well by the time I started residency I took off my Hijab, and at that time I felt like a wimp because I felt I was catering to societal pressure. Honestly, it was a lot harder on me to take it off than it was to put it on.

As it was previously mentioned, Sama also shared her experience when she was confronted with Western norms at her workplace such as shaking hands with men who are not related to her. Although she did not feel comfortable with this gesture, she said, *“...since it is so common here... but sometimes I feel awkward but do not know how to say it so I just end up shaking my hands with them”*.

However, for Nadia, catering to societal pressure in a way turned out to be a positive experience because it helped her become more confident. She recalled her experience, when she was supposed to teach a group of medical students. She explained:

So now I can talk to whomever without any fear. I am able to teach – like this was maybe you know one of the impossible things that I would be able to do because I

was really shy of talking to others, imagine I am going to teach. Now I am able to teach with all confidence and I feel happy about it. I can even argue with consultants on patient management in a polite way and they would accept it you know.

Nadia's comment reflects the importance of how in the Canadian culture you are encouraged to be outspoken which was quite different than what she was used to back home in the Middle East. Hence, for Nadia conforming to societal pressure by learning to be more outspoken and confident in a way helped boost her morale and made her feel more settled.

Professionalism

Another strategy that the women in this study adopted to overcome challenges was to deal with situations in a professional manner. According to Epstein and Hundert's (2002) definition: "Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (p.100).

The participants in the study used professionalism as a way to cope with difficulties without letting them hamper their work performance. For instance, Sama talked about how she would translate her Islamic faith to clinical practice when she discussed the importance of the medical profession in Islam and how the role of a physician is "*highly looked upon*". She mentioned, "*I do not think there is anything bad written about a Muslim woman doctor touching a naked man as her patient, so from a religious point of view it is seen as a part of my job as the healer*". According to Sama,

the Islamic faith viewed doctors as healers, regardless of the fact if they are male or female. As female doctors, they were allowed to treat patients and no one can forbid them. Hence, the role of professionalism not only helped the Muslim woman deal with social pressure they faced in their workplace, but it also contributed to their understanding of women's role within the Islamic faith.

Nadia talked about her experience with the nurses who had a hard time taking orders from someone who was a *“non-Canadian physician”* and tried to *“irritate her”*, she said, *“so I was very professional in giving them the orders and explain it to them, like not only order but also try to explain it to them why am I doing this and so forth and so on”*. The above comments illustrate the notion that the social pressure women faced in their working environment was overcome with the help of professionalism as it allowed them to maintain their focus of accomplishing their task, thereby, preventing it from hindering their work performance, in any way.

Balancing Islamic practices with work obligations

Women in the study described how they managed to balance their Islamic practices such as fasting and praying with the work obligations. According to the participants in the study praying during their work hours did not interfere with their work performance. Zoya mentioned:

If I am in the middle of something, let us say I am doing a surgical procedure and say the patient is bleeding and I am in the middle of it, I will never leave her. So in those cases, I will wait until it is done, and then go pray.

Nadia also commented on the ease of finding time to pray during her residency when she said, *“...for the Friday prayers you know we are allowed to go without any*

problem and the same thing with the Islamic festival Eid. They would give us time off”.

According to Nadia, praying on days other than Friday was also not a problem, because she believed that if you had the intention to do something, then you can find a way to achieve it, when she said:

There is always time to pray, no matter how busy we are. Even if we are really busy, I would just go tell my staff I have to go pray for 10 minutes, he would say absolutely. Never give you any look.

However, in terms of fasting in Ramadan “*the month of fasting*”, the participants felt it did affect their performance and was a lot harder than praying, hence required more adjustment. For instance, Zoya explained, “*but fasting I would say, no matter what people would say I do find that it does affect your ability, the concentration level is not the same.*” In order to better accommodate fasting with her work obligations, Zoya described as mentioned earlier, “*I did cut short on my clinic hours and start late and finish up early and go home and take a nap just before the breaking of fast time. So it does affect performance a bit*”.

Sheila also talked about how fasting was harder for her especially during the residency training because she did not have the option to have flexible hours. She expressed:

So as a resident, when you are doing call, fasting is particularly hard. But I think you can do anything if you have the mindset, if you have the faith to do it. Like as a resident, you would work like a dog, do all kinds of hours.

Nadia observed that during the month of Fasting, her colleagues would respect the fact that she was fasting and would “*try to not eat in front of her*” or she said, “*would*

apologize if they are eating, because we have teaching every day and there is food every time. So they would say we are sorry”. Hence, Nadia described that there was not much effort she had to put in to balance fasting with her work obligations, because of her disciplined Islamic upbringing, fasting had become like second-nature, she said, *“I am used to this”*.

According to the participants in this study, balancing Islamic practices with work obligations was a manageable task as long as they had the intention to do it. It also demonstrated their strength of conviction to overcome any hardships and in the process gained leverage because of their resilience. Hence, the women found themselves in situations which gave them the freedom to make their own choices, thereby, facilitating growth and positive change in their lives.

4. Struggling with ethical contradictions with religious and professional duties

The participants in this study learned how to navigate through the differences between Islamic faith and the Western Medicine. For instance, Sheila found it noteworthy to mention that the issue of same-sex care requests had earned a lot of attention because she expressed:

I felt there was almost a hostile response from the care providers. Like males or females non-Muslim providers did not like this request. They felt almost offended by that. Actually when I wrote the paper, I found it very odd as to why women minded it more. And that’s the thing for me; people here do not understand where the request is coming from. Not just for women, but also for Muslim women in particular there was a hostile response. Like a lot of people said that to me, why do they feel they deserve to have that, because they would not have this privilege

in their own country? Like why do they come here and request a female care giver, when they do not even have that necessarily in their own country.

The above comment implicitly reflects the notion that the non-Muslim care providers might react negatively to the same-sex care requests precisely because they would feel they were being chosen to provide care because of their gender which would undermine their expertise and capabilities solely as a doctor. However, Sheila argued that the issue could be dealt with effectively as long as the care providers would understand that, *“it is a reasonable request and all they have to do is respect the request...instead of abruptly saying no and feeling offended”*.

However, when Zoya encountered herself in a similar position where she realized Muslim women came to her because of her gender, she said:

So the majority of my patient population is South Asian. Majority of them is female because I am a female so they are more comfortable which is very understandable because my own family doctor is a female and even I would prefer to have it that way.

Both Sheila and Zoya's statements reflect the significance of their Islamic values in shaping their perspectives. For instance, both of them explained that due to their own upbringing with Muslim values, they could better understand why a woman would feel more comfortable with a female care provider.

Sama also discussed how having a strong faith in God could help her better understand the situation of her clients when they would talk about praying to God for help. She said:

Sometimes when the patient is really very sick and you are trying to do whatever you can do to save their life. But you have this inner satisfaction that you know I am not God, I cannot save this person. There is the role of prayer as well. So for example when I tell a patient that basically you are dying, you have cancer which has spread to your whole body and there is no chance of your living. And then when the patient tells me oh no there is still someone who I can pray to. So in that case, I can understand them better because I also have a strong believe in God. You know God can do anything. I think from our religion background we can understand this faith at least and maybe Western people may not, they might say oh no, no one can save. But at least from our point of view we can say yea there might be a way and God can do anything, so one should still pray. In that sense, it helps and maybe Western people may not, they might say oh no, no one can save you.

The above comments highlight the fact that the women felt their Islamic values have shaped their experiences in a rather positive way, but it also defines the notion that the women have made some assumptions about the Western value system, similar to those of their Western counterparts - who looked down upon the requests of same-sex care requests from the Muslim women, without having an understanding of “*where the request is coming from*”. Upon further scrutiny, it could be said that the differences in perceptions usually stem from the lack of understanding of other people’s beliefs and cultures which could be a source of stress and conflict, if not handled in a sensitive manner.

Other ethical contradictions that the participants encountered were with regards to patient consent and privacy. For instance, Zoya talked about the difference in ethical standards in Canada compared to what she experienced back home in South Asia. She explained:

You can give birth control to a seventeen year old without talking to the mother and I was surprised at that, because back home we can not do this. For us it was like learning a new thing, so you learn a lot while going through the exams.

Zoya also talked about the importance of patient privacy in Canada, when she said, “*back home if my mom would come and ask the doctor to give her my entire medical history and they will give it to her*”. Zoya felt that the patients here in Canada had more personal autonomy.

Whereas, Sama noticed that the patients in Canada were more knowledgeable and aware of their rights when receiving care. She mentioned:

I think patients here are more knowledgeable and the system here is such that you have to ask the patients about everything whether they would like something or not. For example, consent is very important; you can not do anything against their wish or will. This is different in back home, where if we think this is needed for the patient, we would just go ahead and tell them and they would say, yes.

The women in the study felt that the relationship between the doctor and patient is a more democratic one, which further demanded the need for professionalism in their practice. For instance, although some ethical contradictions such as prescribing birth control pills to seventeen year old teenagers, abortion, or preserving patient privacy even from the parent is something that contradicted with Zoya’s own values, she would rather

handle these situations in a more professional manner, when she said, “*we just do what is ethical and medical system over here*”.

Sheila also discussed how she negotiated her way through ethical contradictions such as abortion. She said:

As a physician faced with somebody who wants one I can not give her my views.

That’s not professional, that’s not even relevant to the equation. So I have to deal with her request in a professional manner without allowing my views to color my treatment of that patient.

The women described the need to balance the ethical contradictions with their Islamic obligations in a professional manner, without letting it hamper their work performance. The importance of professionalism in the medical practice of the women in this study had some advantages and disadvantages, “because the word *professionalism* carries with it so many connotations, complexities, and nuances” (Swick, 2000, p.612). For instance, if on the one hand, professionalism helped the women in this study cope with social pressure and prejudice, but on the other hand, the same definition of professionalism expected them to behave in a way that would have them compromise their own values in order to adhere to the values of the Canadian system. However, there are still ongoing debates about ways to arrive at a “common understanding of what it is meant by medical professionalism” (Swick, 2000, p.612). More research and dialogue are needed to articulate different ways in which people define professionalism related to medical profession.

5. Role of the Canadian society in facilitating positive change

The participants revealed that the Canadian society played an important role in helping facilitate positive change which made adjusting to the new environment easier. Some factors that attributed to the positive changes the women encountered are: the Canadian system is based on meritocracy; cultural safety in the workplace; and chance to speak out for change.

Canadian system is based on meritocracy

The immigrant women in the study noticed that the Canadian system was primarily rooted in merit which was evident in terms of the opportunities they were getting in recognition of their hard work. The women demonstrated gratitude toward the Canadian system for acknowledging their efforts and by placing them in positions that enabled them to tap into their hidden potential. For instance, Sama talked about how she noticed that the Canadian system recognized her hard work:

At least they give you an option, like in my case they gave me this position for a year to see my performance, in which I have to prove myself and then they would extend it to full time position. This is something positive and we should acknowledge it and be grateful for that. For example, I have heard that in other countries even in Muslim countries, if you work hard for years, they would still not give you the same status as their own citizens or outsiders, but Canadians are really good in this regard, they give you citizenship and other opportunities.

Nadia also discussed her observation about how she perceived the Canadian system to be truly democratic in nature and based on horizontal relationships. She felt that once you prove yourself through hard work and dedication, they would acknowledge

your efforts through praising you and giving you further opportunities to cultivate your career. She expressed:

For example, if I plan to do something on a patient, even if they think I maybe somehow wrong, they would still say let's just do this and see what happens, let's try it, or I agree with you although I would rather do this, but you know what let's just try your way. So they would try not to change your plan.

Nadia talked about how once the Canadians realized how “knowledgeable” you were, they would try their best to make you feel a part of their system by letting you take on leadership roles, she said, “...*I got that wonderful opportunity to be a team leader...so I see that as quite an achievement especially for me as a Muslim woman. That was the best period in my life*”.

The participants did not hesitate to acknowledge the fact that once the initial hesitance came off, the Canadian system would make an effort to integrate people from the outside. As a result, it helped the women reach their true potential and feel more settled in their lives, knowing that achieving this level of success would have been a lot harder in any other society.

Cultural safety in workplace

Another factor through which the Canadian society facilitated positive change was by providing the Muslim women with the kind of environment where they experienced cultural safety. Cultural safety in workplace requires the people to be “respectful and sensitive to the values, beliefs, and practices of others” (Fonte & Horton-Deutsch, 2005, p.42). The notion of creating a culturally safe work environment was evident when the Muslim women in this study found themselves in a position to educate

both the Muslim and non-Muslim women about Islamic practices. For instance, Sheila talked about how she felt comfortable sharing her views on religion with her staff, she expressed:

Also in terms of people's questions or comments about these things: when I am frank with people or they know me I am very open about things, even the nurses in the hospital, if I feel comfortable with them I would feel very free in talking about religion and things like that.

Similarly, Sheila felt that she was playing an insider/outsider role within the Muslim community based on her interaction with some of her Muslim clients where she felt the need to remind them of Islamic practices with regards to pregnant women, she said, *"I know you do not have to fast in Ramadan and there is a reason for that"*.

Zoya also reflected on her experience when she was confronted with cases of Muslim clients who wanted to get an abortion which she believed contradicted Islamic values, she described, *"and sometimes Muslim women come to me and I do a bit of a lecture. I do give them a small speech about Islam"*.

The above comments highlight the insider/outsider role the women are playing within the Muslim communities as they feel they could help bridge the gap that exists in terms of both Muslim and non-Muslims understandings of Islamic values. For instance, Sheila argued the case for the issue of same-sex care requests and reported how, with a bit of empathy and understanding, the source of conflict may be resolved. From a Muslim woman's perspective she detailed:

I think it's a matter of education. So the really educated Muslim women, although they would prefer to have a female caregiver... but they know that in the end it doesn't matter. What you want is a healthy delivery and a healthy baby.

However, from a non-Muslim care provider's vantage point, she stated that the hostile response should be replaced with an understanding of the fact that due to technical constraints such as the availability of the physician could prevent them from accepting their requests, she said, "...just put it in a polite way that "I would love to deliver you, but that is how the call system here works"...instead of abruptly saying no and feeling offended".

Sama also shared her experience when she reported there was an influx of Muslim women practicing in the healthcare organization she currently works for. Sama described that the Canadians were used to seeing Muslim women in hijab, because of which she did not have to face a lot of hardships during her resettlement phase. She said, "...I did not find very many negative experiences here, plus there are too many Muslims already working here in this hospital, so maybe that's why since everyone is used to".

Nadia discussed that the acceptance rate to the Canadian healthcare organization for Muslim women is higher than Muslim men. She said, "...like if you come here, you will see more Muslim women accepted than men in every program, every specialty there are at least three or four Muslim women".

Chance to speak out and act for change

The women in this study realized that because of the opportunities they were given, it allowed them to speak out and act for change. For instance, Sheila shared her educational experience, when she said:

Before coming here, I actually did a masters in bioethics through UofT so I am very involved in ethics as well . One of my projects during masters was to look at same sex care requests. Not necessarily Muslims all the time, but a lot of women who only request to have a female health care provider, which is really not look upon favorably in this field. So I wrote a paper on that because I felt that it was a reasonable request, but it is something we cannot always cater to because of the on-call care system and all.

Sama also talked about how getting into the Canadian healthcare system without any pre-training created some hurdles for her, but once she “voiced her concerns”, it acted as a catalyst for social change, she explained:

But then next year what they started was with all the IMGs (International Medical Graduates), they gave them pre-training. They started giving them one month pre training in which they would just rotate them into different departments to get them used to rather than giving them responsibility of twenty patients on first day. Like they would just observe. So at my time it was a bit difficult, but Alhumdulilah (by the Grace of God) it is gone and I am sitting here today (smiles).

The women in this study mentioned that the opportunities they were provided with helped them make positive contributions to the image of Muslim women in Canada, thereby, helped them better assimilate themselves as role models within the Canadian health care contexts. Sheila expressed:

I think now there are good opportunities available for Muslim women here. Like I noticed that the national society of obstetricians has a poster they put up and it has a picture of Muslim woman in there as well, which really pleased me.

To summarize, this chapter presented the five common themes that were identified across the narratives and were discussed in detail using direct quotes from their stories of the participants. Those themes were: importance of hijab; experiencing a lack of sense of belonging; gaining personal freedom through strategies of empowerment; struggling with ethical contradictions between religious values and professional duties; and the role of the Canadian society in facilitating positive change.

CHAPTER SIX

Discussion

In this chapter I explore the findings from the preceding chapter in relation to the previous literature on the experiences of Muslim women in Western societies and further engage in reflecting on the relevance of the experiences of Muslim women healthcare professionals within the health professional education framework, especially within the Canadian healthcare context.

Importance of hijab in shaping the experiences of Muslim women healthcare professionals

The hijab or the headscarf worn by the Muslim women is considered to be the most visible symbol of appropriate modesty in Islam (Hickey, 2010,). “Several Muslim clergy place a strong interpretive emphasis on a Qur'anic passage (S. 24:31) that urges women not [to] display their beauty and adornments but rather to draw their head cover over their bosoms and not display their ornament” (Bartkowski & Read, 2000, p.339).

The findings of this study demonstrate that the hijab played an important role in shaping the experiences of the Muslim women within the Canadian healthcare context. The women in the study discussed how the hijab provided them with a sense of belonging to people with similar values. A study done by Pearce (2008) suggested the notion of particularized trust which means having faith in only those people who are from your own background (Pearce, 2008, p.7). According to the findings of this study, particularized trust is higher within ethnically diverse communities, because individuals who endorse particularized trust in their social interactions have faith only in people who

belong to the same background as theirs, thereby, helping weave stronger ties within minority communities. The author concluded that as a result of this attribute, people from the minority group form assumptions about someone outside of their community depicting them as not able to comprehend their cultural or religious practices. Hence, people who adhere to the practice of particularized trust in their social inter relations, “tend to stick to themselves and others like them” (Pearce, 2008, p.7). This appears to be the case in this study because the participants talked about experiencing a stronger sense of belonging to people from their own community which was evident in their practice.

In some aspects, religious values helped foster a stronger sense of unity among the Muslim women, but on the other hand, it did create some friction during the process of adjusting to the Canadian environment. For instance, some participants faced struggles during the acculturation phase because of the perceptions people of Western nations have about Islam, in particular, Muslim woman. All the participants talked about “this unsettling gap between public understandings of veil as a symbol of Muslim women's oppression and their own personal experience of it” (Kirmani & Phillips, 2011). Among other problems, the central issue of this misconception is the homogenization of the Muslim community, as Talhami puts it: “What is wrong with this picture is that it provides a composite pattern of generalizations, erasing all economic, historical and cultural differences between clusters of Muslims” (Talhami, 2011, p.460). The women in this study reported to have been subjected to prejudice or social pressure in some way because of the headscarf, which they articulated stemmed from lack of understanding about Islamic traditions.

It is noteworthy here to mention here that social pressure also stems from the assumptions Canadians have of Muslims and Muslims' assumptions about the Canadian norms. The findings of my study indicate the importance of cultural awareness, because something that is acceptable in one culture may be considered rude or offensive in a different culture. For instance, the issue of shaking hands is based on Islamic rulings and has more to do with religion than culture, it nonetheless, reflects the importance of the impact of one person's norms and values in shaping the experiences of someone else. In Sheila's case, the comment made by the patient who thought she was a foreigner, did put her in an awkward position where she felt the need to defend herself by explaining that although she wears the headscarf she is still very much embedded into the Canadian culture.

Nevertheless, as previously stated, in research done in the United States the women believed that the hijab has positively shaped their experiences, as it allowed them to strengthen their relationship with God by being able to live their lives according to Quranic principles, and provided them with a sense of identity that helped them forge stronger ties with people of similar values (Ahmed, 2011). As Williams and Vashi (2007) suggested, "these young women are active agents and are able, to some degree, to create their own lives. hijab helps them do so, while also keeping them anchored in a traditional identity and avoiding potential anomie" (p.284).

According to the women in this study, the hijab is seen as an opportunity to help defy stereotypes (Ahmed, 2011) about Muslim woman which they said is demonstrated through the active role they are playing in their professional lives. Jamal (2011) suggested that the experiences of these women could portray an "emerging image of the

willfully veiled Muslim woman, who is seen to defiantly negate western liberal notions about social development and secular modernity” (Jamal, 2011, p.206). Jamal’s suggestion is supported by the women’s viewpoints in this study in terms of the way they viewed themselves as agents of change and felt emancipated in the process. According to a study done by Droogsma (2007) on redefining the veil, the donning of the hijab allows the women to feel empowered as “they refuse to define themselves according to others’ terms, which communicates their oppositional standpoints to each person who comes into contact with them” (p.313). The results of the previously mentioned study are consistent with the findings of my study. Hence, “the veil, then, may function as an impetus for self-definition within a framework that allows women to be both Muslim and independent” (Droogsma, 2007, p.296). Also, in my study the Muslim woman who took the hijab off during her school years, reported to have built a strong affiliation to her Islamic practices. Hence, as the previously mentioned research reported, “Muslim women who are active in their religion, both those who wear hijab and some who did not consider religious involvement as an important tool that affects their identity” (Williams & Vashi, 2007, p.272). According to the women in this study, adhering to Islamic practices is an integral part of their daily lifestyle. As other authors highlighted, it allows the young Muslim women to create some cultural space for themselves by “negotiating their dual identities as Muslims and [Canadians] and gives them the opportunity to be part of both worlds” (Williams & Vashi, 2007, p.272).

The participants’ narratives unearth the notion that that Islamic values act as a liberating force in their lives. Kirmani and Phillips (2011) suggested that culture and patriarchy in Muslim societies are the real cause for women’s oppression, which has

nothing to do with religious teachings that in reality depict the privileged status that women enjoy in Islam. For example, Ali, Mahmood, Moel, Hudson and Leathers (2008), stated that “women’s roles in Islamic societies have been largely shaped by social, and economic factors and other cultural forces” (p.45). These authors argued that it is important to draw a distinction between cultural practices and Islamic teachings in order to gain a deeper understanding of the experiences of this population. The findings of the previous literature is consistent with the results of this study that described the Muslim women’s agency in portraying a positive image of Islam that is “contrary to some of the ethnic/cultural practices which oppresses the rights of women” (Ali et al., 2008, p.45).

Although hijab was one of the common factors for feeling alienated in their workplace, the women in this study also talked about other attributes such as cultural and educational differences that contributed to feelings of isolation at their workplace. For example, the participants articulated that due to the fact they had international medical education they were initially perceived as less competent. According to the findings of the previously mentioned study done by Pearce (2008), “education location is also related to a higher sense of community belonging. Immigrants who received their education in their host country demonstrate higher feelings of belonging to it”. In the analysis Pearce (2008) suggested that immigrants who “spend a considerable time in the host country developing good language skills, and graduating with domestic credentials have an easier time bridging the gap between their ethnic background and geographic community” (p.13). That notion is consistent with the findings of this study, because the three participants who do not have the Canadian educational experience, Sama, Zoya, and Nadia, described the emotional stress they went through because they had to work much

harder to prove themselves, because initially people did not think they were as competent as the other local medical graduates. One of the ways through which the participants had overcome the social pressure is through overachievement. As the women with international degrees reported in this study that they had to work much harder to prove themselves in order to thrive in their work environment.

According to a study done by Lutgen-Sandvik (2006) about different forms of workplace bullying, the author stated that, “the harm to workers runs the gamut of human misery including anxiety, depression, burnout, frustration, and helplessness . . .” (p.406). The author pointed out the importance of implementing effective organizational policies in order to help reduce workplace bullying. In the analysis, it was articulated that “workplace bullying is not just confined to the bully and the target, but has its negative repercussions on the entire work unit, as it is reflective of their organizational effectiveness [or lack thereof]” (Lutgen-Sandvik, 2006, p.406). In this study the participants shared how the adjusting phase in the new environment affected their emotional and mental well-being. The women reported that they experienced stress either in the form of lack of support from the management, being judged by colleagues or other staff members such as the nurses, or feeling unaccepted by the patients in the initial phase of their residency training. It can be implied that the social pressure affected participants’ well-being and deprived them of opportunities for socializing with their colleagues because they had to be strictly academic to keep their position intact. This stance further supports the notion that not only religion, but also perceptions of the people of the host country who deem that the Western educational system is superior to other societies, play an important role in shaping the experiences of these Muslim women.

Experiencing lack of acceptance in the new environment

The findings from the previous literature highlight that negative attitudes are more intense towards Muslim women who wear the headscarf (Cole & Ahmadi, 2003; Saraglou et al., 2009). However, the results of this study indicate that the veiling is only one part of the problem that leads to feelings of isolation. In this study, even the participant who did not wear the hijab, Zoya, experienced feelings of alienation in her work environment due to conflicts related to ethical aspects of the medical profession, cultural habits, workplace etiquette, etc.

It is important to note that the participants associated lack of common ground and familiarity with the Canadian culture as one of the primary reasons for feeling isolated in their work environment. Both Zoya and Sama described that the way they were brought up in South Asian cultural environment, had a profound impact in shaping their experience, which was evident in terms of people's attitudes towards them such as being more reserved and less friendly. Hence, the lack of exposure to the Canadian environment coupled with their South Asian upbringing contributed to their feeling of lack of acceptance from their work colleagues and other staff members, causing cultural clash. Further, it is important to differentiate between Islamic values and cultural values. The women in this study who were raised in South Asia appeared to be heavily influenced by their cultural values. For instance, cultural practices shaped their social interactions and heightened their isolation at their workplace, because they did not find any common ground with their coworkers in terms of TV shows, hobbies or sports. On the other hand, religious values are more spiritually grounded and reflected in fasting, praying or the practice of veiling. The religious values have remained fairly constant

ever since Islam was founded thousands of years back, however, cultural norms are ever-evolving.

According to Browne and Varcoe (2009) culture is “a relational aspect of ourselves that shifts and changes over time depending on our history, social context, past experiences, gender, professional identity and so on” (p.36). The findings of this study emphasize the fact that looking at culture from a relational vantage point will enhance understanding about the experiences of the Muslim women because it encompasses the way we interact with others (Browne & Varcoe, 2009). The participants indicated that the inability of the people of Western society to differentiate Islamic faith from cultural differences and cultural values heightened their isolation at work. For instance, Zoya and Sama expressed feeling uncomfortable socializing with their colleagues because of the fact that they do not share the same interests in terms of cultural variations such as hobbies, sports, TV shows etc., with the coworkers which made them feel like an outcast. Hence, the participants feeling of a lack of acceptance in the new environment unravels the notion that it is an issue that is primarily affected by a person's cultural background and further heightened by the lack of exposure to the Canadian environment. It might have no relationship with the individual's religious background, in any shape or form.

Sources of empowerment in the Women's Lives

Regardless of other's perceptions of the image of the Muslim women or their educational background, the women indicated that their education provided them with opportunities which allowed them to rebuild their status in the Canadian society. O'Toole and Were (2008) articulated the importance of “the type of material culture that is embedded in a set of practices...and represents social and symbolic meaning that is tacit

in nature and is reflected in the culture practices of the group or the organization” (p.621). The authors emphasized the importance of different forms of material culture that is reflected of individual’s status. O’Toole and Were (2008) suggested that,

The workspace of an individual is a significant indication of their power in an organization. Physically separated offices insulate each member and give a measure of autonomy to those within them, and the size and appointments of an office serves as a powerful indication of hierarchy. (p.630)

The notion of the significance of one’s workspace was reported by the women in this study which allowed them to communicate to others their status in society. The women felt empowered because their educational experience provided them with the freedom to make their own choices, that is reflected in their practice, such as flexibility to reschedule work hours, office space with personal secretary, and prestigious titles are all indicators of ways in which they define their individual position within the broader contexts. However, it is important to take into account the privileged status of physicians in a society which has carved out the Muslim women’s experiences in a positive way, which may not be common to Muslim women in different walks of life.

Another way the women felt empowered was through finding themselves in a position to educate both Muslim and non-Muslim women about Islamic beliefs. “As women, Muslim women are outsiders/ insiders within Muslim communities” (Ahmed, 2011, p.500). The women in the study described the importance of educating people about the misconceptions about the Islamic beliefs. Ali et al. (2008) suggested:

Islam was a liberating force in the lives of women in 7th century Arabia when it was first revealed and elevated the status of women. However, they also claim

that Islam has been misunderstood, misinterpreted and misused by Islamic extremist movements in order to oppress women. (p.45)

This finding is consistent with the results of this study that demonstrated the participants' desire to help clear misperceptions and educate people about the Islamic practices. For example, Sheila brought up the issue of same-sex care requests and discussed ways in which the hostile response from the non-Muslim caregivers can be dealt with, by respecting the request and informing the patients about the restrictions of the on-call care system, instead of abruptly refusing to provide care and getting offended. All the participants found themselves in places where they got an opportunity to educate people about Islam. Sama and Nadia through their hijab, which they articulated would portray the image of career-oriented Muslim women in order to deconstruct the stereotype that Islam is restrictive in any manner; whereas, Zoya felt the need to educate the Muslim women about the Islamic stance on abortion. According to Kassam (2011), the narratives of the Muslim women "speak to an Islam that is 'modern', 'pure' and 'authentic'...which encourages women to be educated, empowered, and ethical, and to negotiate an identity 'between' 'Islam' and 'America/Canada', as a result, it allows the women to engage in societal issues" (p.556). The suggestion of Kassam is supported by the findings of this study, as indicated by the narratives' of the participants which enabled them to help bridge the gap, while strengthening their own position of power in the host society.

The women also felt empowered by adopting certain strategies as a means to cope with social pressure and prejudice. For instance, the participants articulated the importance of having faith in God in their practice, because it comforted them in times of

distress. “The feelings of reliance on God accompanied with the belief in his omnipotence are the basic pillars of Islamic piety” (Jouili, 2011, p.55). The essential faith in Islamic belief system provided the women with the stability to sustain hardships. The study done by Ali et al. (2008) suggested “that religion helps women to maintain sense of peace in the face of stress and societal upheaval” (p.38). It also appears that the women found faith in God not only as a means of coping with stress but leveraged power in the process, because they chose to rely on God; as ‘developing God-consciousness’ (Jouili, 2011, p.58) within themselves was a result of their own understanding of Islamic principles. The women in this study discussed aspects that are congruent with the views that they were “defined by different virtues and hence, it is about other agencies and other rationalities and other freedoms than the particular forms considered to be legitimate in modern liberal culture” (Jouili, 2011, p.58). Previous literature focusing on the importance of Islamic faith in Muslim women’s lives talked about seeing religion as a means to cope with difficulties (Fonte & Horton-Deutsch, 2005; Hammoud et al., 2005 & Odeh Yosef, 2008) which is similar to the findings of this study, as the women reported that they viewed religion as a way of feeling emancipated and empowered. In the previously mentioned study by Ali et al. (2008), the authors stated that “many women report significant and empowering spiritual and religious experiences that provide individual life meaning and support in spite of the institutionalized patriarchy associated with religion” (p.38).

Another strategy of coping with hardships found in this study was professionalism. The women in this study reported that being professional was an important part of their religious duty. Islamic belief system is grounded in the

understanding that God's message to humans is based on the notion of justice (Jouili, 2011). "According to this belief, then, Islamic rights are not only cemented into a religious-moral framework of divine origin, but are also fundamentally linked to a certain ethical practice...reflecting in notions of obligation, responsibility and duty" (Jouili, 2011, p.58). The women in my study stated that Islamic teaching are applicable to every aspect of their lives. Hence, "the understanding between the relation of rights and duties explains the participants' emphasis" on being able to deal with difficult situations in a professional manner by not letting their personal views hamper their work performance (Jouili, 2011, p.58). Whereas, on the one hand, professionalism enables the participants to sustain challenges, on the other hand, it also implies they have to compromise their own values in order to adhere to the Canadian ethical standards which they felt at times, contradicted with their own religious views. For instance, views on abortion, prescribing narcotics, patient consent and privacy. Hence, although professionalism is used as a tool which reflects the women's resilience in this study, it also illuminates the notion that due to the ethical contradictions between Islamic and Western Medicine, it would create some tension, which they handle in a rather "professional" manner. In other words, professionalism heightens the women's understanding of their role as a caregiver, as it allows them to prioritize their work obligations over any other identity such as gender, ethnicity, class or religion.

The theme of empowerment in the participants' narratives reveal the importance of individualism and freedom, reflecting "broader sociocultural trends of individualization, which may undermine the potential significance of other factors such as gender, religion, or societal pressure" (Scharff, 2011, p.123). For instance, Sheila felt

empowered in knowing that she made the informed decision to take off the hijab, but at the same time, she was catering to societal pressure and feeling disempowered in the process. According to the study done by Scharff (2011), “individualistic talk evades political discussions because everything is cloaked in the seeming neutrality of it only being an individual’s opinion” (p.125). Sheila’s individual decision to take off the hijab is self-aware and self-determined, her choice is however, highly regulated in the sense that it triggers her to adhere to the prevalent notion of feeling accepted by looking like everyone else in her surrounding (Scharff, 2011). The participants’ shared narratives reveal their perception that the difficulties they faced at the workplace are not related to inequality or any form of discrimination because the women wanted to present themselves as individuals who are empowered (Scharff, 2011, p.123). Further, the participants narratives also imply their effort to defend their status in society. For instance, the Muslim women are “interested in representing Islam and themselves in a positive light (Williams & Vashio, 2007, p.274). The findings of the previous literature are similar to the results of this study because the participants seem to be aware of the stereotypes people have of Muslim women. They are not “suffering from ‘false consciousness’ or ‘lulled into a false sense of equality’” (p.127).

The participants’ desire to deconstruct the misconceptions about the Muslim women through their actions and not words demonstrate their preference to be perceived as free individuals in a position to act for social change. “They are determined to ‘hold tight and stand strong’ and regard individual hard work as a key to success” (Scharff, 2011, p.127). According to Sama, there is not much point in “*saying it out loud*”. Therefore, these Muslim women’s narratives may confirm “the research participants’

reluctance to engage in a critical analysis of unequal relations as something that threatens their positioning as self-determined empowered and free subjects” (Scharff, 2011, p.126).

Role of the Canadian society in facilitating positive social change

The participants also discussed the importance of the Canadian healthcare environment in helping facilitate positive social change and growth in their professional lives. According to the participants’ narratives, the multicultural policies of the Canadian system promote a learning environment: “Canada’s reputation as the birthplace of multiculturalism is widely acknowledged, because of the ease by which Canadians across regional, class, age, racial and ethnic divides embrace this notion”(Haque, 2010, p.81). Most participants in this study talked about encountering cultural safety in the workplace where they felt they could share their views on religion with other staff members without any fear. According to Hoerder (2000), the Canadian multicultural policy “promotes creative encounters and interchange among all Canadian cultural groups in the interests of national unity” (p.293-294).

The participants in the study also discussed the importance of meritocracy in the Canadian healthcare system. Participants acknowledged the fact that the Canadian system is embedded in meritocracy which is based on the idea that “the primary criteria for assessment of a social organization must be the performance of the individuals” (Neves, 2000, p.335).

It is noteworthy here to mention that the studies reviewed in the previous literature were mostly done in the United States which highlighted the hostile attitudes participants’ faced post September 11 event (Byng, 2010; Cole & Ahmadi, 2003; Hammoud et al., 2005 and Kulwicki et al., 2008). It is important to acknowledge that the

Canadian environment seems to have responded to the political conflict in a more sensible manner. For instance, the women in this study reported that the Canadian health care system allowed them to realize their true potential by acknowledging their hard work and providing them with opportunities to cultivate their career. According to the analysis done by Berry (2000) on the mutual attitudes among immigrants and ethno cultural groups, “the Canadian environment not only allows for maintenance of heritage cultures and identities, but also provides opportunities for full participation of all ethno cultural groups in the life of the larger society” (p.724). The participants in this study expressed that they immensely valued the leadership opportunities they were provided with in Canada, as they articulated it was harder for them to attain such position in their own country of origin. As a result, the growth and success which the participants achieved, doubtlessly, acts as an important mark in shaping their perspectives about the Canadian society in a positive light.

Importance of Agency in the Women’s Lives

Further, as demonstrated in the results of this study, participants’ desire for social change may serve as an indication of the Muslim women’s agency to redefine their role in the Canadian society. Bilge (2010) explored the concept of agency in the veiled women through studying the intersectional approach, where he demonstrated that, “agency is central to the action-model, which attempts to grasp individuals’ capacities to act independently of structural constraints, or against them” (Bilge, 2010, p.12). According to a study done by Elder and Hitlin (2007), on the concepts of agency, the authors stated that an individual’s actions reflect the social conditions or goals they aspire to achieve. The findings of this study support the notion of “Muslim women’s agency and

their determination to defy the perception of passive and oppressed Muslim women in order to claim the Islamic authenticity on their own terms” (Zahedi, 2011, p.200). The women discussed the importance of their insider/outsider roles and how it provided them with a chance to speak out for change. Hence, the “women aspire to empower Muslim [Canadian] communities by utilizing their unique position as Muslims and believers in [Canadian] values – liberty, personal rights, and democracy, thereby operating as agents of change both in [Canada], and by extension, the world over” (Zahedi, 2011, p.199-200).

Further, Elder and Hitlin (2007) highlight the importance of self-reflexivity in helping people to engage in agentic actions. “The self is an organized, and interactive system of thoughts, feelings, identities, and motives that are born out of self-reflexivity” (Elder & Hitlin, 2007, p.173). The results of this study emphasize the importance of reflexivity in these women’s lives in terms of the way they view themselves in the large scheme of the Canadian healthcare context; and how they choose to respond to various challenges in their environment. Hence, as those authors suggested, self-reflexivity as an approach “captures both individual innovation, the ability to act outside of social dictates, and a more socially mediated collaboratively generated aspect of the self, which may heighten one’s capacity for agentic action” (Elder & Hitlin, 2007, p.174).

This study may also heighten the understanding of Western educators in helping them engage the students and themselves in activities that promote “the unlearning of one’s own privilege in order to provide grounds for forms of self-representation and collective knowledge” (Giroux, 2009, p.86). The findings of this study highlight the importance of awareness of one’s own position and attitudes in helping create a more culturally safe environment. In order to implement reflexive practice, institutions and

other systems must be willing to provide the Muslim women, other professionals, and clients the space to engage in reflection. The women in the study reported the assumptions people of Western nations have about Muslims and Islam, especially, post the September 11th incident. The educators can help bridge the social gaps by creating opportunities that emphasize “the availability of multiple discourses and cultural resources that provide the very grounds and necessity for agency” (Giroux, 2009, p.87). More research in this area is needed to explore the different resources and their impact on agency in creating a meaningful place for professionals and clients to work together.

Summary of Discussion and Potential for change

In this research study, a critical perspective on the experiences of the Muslim women as healthcare professionals in Canada was presented. The discussion in this chapter brings to light the challenges that the Muslim women faced while navigating through the Canadian health system as professionals. The discussion also presented the struggles women encountered because of misconceptions people have about Islam, in particular Muslim women, which depicted them as oppressed and voiceless because of the hijab and other religious practices. However, the results of this study indicate that the active role these professionals are playing in the Canadian society challenges the prevailing assumptions of a woman’s subservient status within the confines of the Islamic law. These findings highlight the need to take into consideration other factors such as culture and education which also played an important role in shaping the experiences of the participants. In addition, the discussion also presents the strategies that women adopted in helping them overcome prejudice which demonstrates their resilience that further challenges the stereotypes that portray them as weak or disempowered in society.

In this study, the importance of the Muslim women's capacity of agentic action is discussed, however further research is needed to elaborate more on the ways these Muslim women respond to different forces in their environment. Finally, the findings of this study reveal the benefits of the Canadian policies which consist of multiculturalism and meritocracy in facilitating positive changes in the lives of these women.

The use of critical narrative inquiry approach in this study helped provide these Muslim women with the space to share their stories to unravel different social, political and contextual factors that play an important role in portraying the image of Muslim women in the Canadian society. The purpose of critical theory is to illuminate weak areas or power imbalance that exist in society in ways that could lead to change (Crotty, 1998). "It's not just about opening up a space for having a dialogue, but having an 'effective' exchange" (Ahmed, 2011, 507) that can help defy assumptions and biases people have towards the minority or marginalized group of people within the larger scheme of society. The kind of change that can be triggered by this study would be through challenging the stereotypes people have about women's role in Islam. Hence, it may allow for a shift in paradigm by placing emphasis on cultural or other differences such as class and ethnicity, rather than generalizing the practices of all Muslims. As a result, narrative studies may help foster a new level of understanding that may be beneficial to Canadian healthcare organizations, policy makers, service providers, and communities in general.

CHAPTER SEVEN

Implications

In this chapter, the implications that have emerged from the study will be discussed along with areas of further research with regards to peculiarities and differences in culture, gender, and religious contexts. I will conclude the chapter by presenting the final considerations which include conceptual and methodological limitations of this study and reflections on my personal story.

Implications of this study for Health Professional Education, Healthcare organizations, and Research

The findings of this study can be used to inform the healthcare organizations, education, and research about the experiences of Muslim women as healthcare professionals who are trying to weave their religious, cultural, and professional identity within the context of the Canadian healthcare organization.

Health Professional Education

In this study education plays an essential role in shaping the participants' experiences. Health professional education strategies can help facilitate effective changes in terms of the way people view the practices of this population. For instance, women in this study reported the misconceptions people with Canadian education/degree have of non-Canadian degree holders. As a result, participants felt judged or less competent compared to the other local residents, which affected their mental and emotional well-being. One of the reasons that contributes to this stressful situation is related to lack of preparation provided in terms of computer training and unfamiliarity with the Canadian

mode of education, before starting the residency training period. Being provided with guidance about education strategies and some training regarding technical skills could help increase participants' level of competency and as a result, alleviate some of their struggles.

Other issues participants raised were pertaining to the perception people have of their Islamic practices such as hijab, and other traditions which at times, act as barriers in building a rapport with colleagues or clients. Hence, it is important for educational programs to implement strategies that can provide information to deconstruct the misconceptions people have about the beliefs of this minority group and “use this knowledge to assist in the empowerment” of the Muslim women within the healthcare framework (Ali et al., 2008, p.46).

In addition, the participants in this study raised the importance of knowledge exchange in helping them establish in the Canadian society. Program developers can create an organization for International Medical Graduates (IMGs) that can provide the new trainees with a platform where they can learn and share from the experiences of people who have been through similar situations

This study also highlights the need to help reduce the differences that the participants faced compared to their Western counterparts. In order to create a more culturally competent environment, the need to educate healthcare professionals about the unique set of cultural and religious practices of the Muslim population takes precedence. One of the ways through which the medical educators can promote awareness is by providing cultural knowledge in a safe environment (Baum, 2007). “This is vital in promoting a positive environment because the workers' personal experiences of political

situation or conflict may penetrate into clinical interventions through the unconscious” (Baum, 2007, p.874). For instance, the perceptions and attitudes people have of Muslims especially after the September 11th event could create a political conflict that would trigger them to generalize the practices of all Muslims. Hence, “the training guidelines for non-racist practice should include such things as helping practitioners to explore their own thoughts and feelings” toward different groups and accept them in ways that would not let the “negativity temper their interaction” (Baum, 2007, p.885).

Faculty/staff should also realize that some of the Muslim women who came to Canada as international trainees or immigrants have been used to different teaching strategies in their country of origin, hence,

Faculty teaching in the beginning of the training should be informed of the trainees’ previous educational experience and be made aware that, despite acceptable TOFEL scores, English may be difficult for them in the first few months until they acclimate to the local English accent. (McDerMott-Levy, 2011, p.276)

In addition, educators should incorporate critical theory perspectives in teaching curriculum for all their students in order to challenge the assumptions and stereotypes people have about the Muslim women which depict them as oppressed. In order to further strengthen the practice and theory, educators could use Baum’s (2007) stance on political conflict in heightening cultural sensitivity and the relational approach suggested by Browne and Varcoe (2009) to promote a more culturally informed environment for both Muslim and non-Muslim students in order to help them gain insights into the practices of one another’s cultural and religious practices.

The findings of this study highlight some of the strategies the participants used to overcome prejudice in their work environment. In order to provide a more culturally safe environment for the Muslim trainees, the educational programs can benefit from these findings as it can help them become aware of the unique challenges that the Muslim women face in the Canadian environment and take them into consideration by implementing training strategies that cater to a more multicultural group of people within the healthcare environment. “The goal of this training would be to enable practitioners to treat people from the marginalized group or different community with the same sensitivity and professionalism as they apply to members of their own community” (Baum, 2007, p.886).

Healthcare organizations

This study may bring implications for healthcare organizations. As emphasized by Bradshaw, Graham & Trew (2009) “focusing on the cultural distinctiveness of Islam is important with the growing numbers of the Muslim population within the multicultural reality of the Canadian workplace environment” (p.388). Healthcare organizations can easily become places that promote cultural insensitivity if the different values and cultural practices of its employees are not acknowledged (Graham et al., 2009). However, taking into consideration the political contexts associated with Islam and the practices of the Muslims in general, especially after the occurrence of the September 11th attacks, “call for an organizational approach that not only acknowledges the difference in cultural values, but also promotes strategies that would help mitigate the negative perceptions people have about [Islam]” (Baum, 2007, p.875). The authors of the previously mentioned studies highlight the importance of implementing approaches to enhance

organizational effectiveness by providing people with the space to reflect on their own views of people from minority groups. The findings of the studies (Baum, 2007; Graham et al., 2009) “contribute to the understanding that cultural sensitivity alone is insufficient when it comes to dealing with issues raised by political conflict” (Graham et al., 2009, p.395). The authors of the previously mentioned studies emphasize the importance of promoting practices by sharing cultural knowledge. Baum (2007) further suggested implementing training policies to enhance political receptivity by creating a safe environment to share cultural knowledge (p. 884-885). This current study provides information that can enhance the understanding of why it is important to take into account the different beliefs system of a cultural group and their political history in order to create a more culturally competent healthcare environment.

In addition, a healthcare organization should recognize the need to incorporate ways to enhance the Muslim women’s sense of belonging toward the new environment. One of the ways to help the Muslim women feel resettled is to implement some sort of representation for the international medical graduates within the healthcare context, which would allow them to share their personal experiences and struggles with people of similar background, in order to better learn and adapt to the new environment. This would provide the women with the “opportunity to explore their own identities, fears and anxieties prior to exploring those of the other community” (Baum, 2007, p.883).

Further, from some of the participants’ stories it is evident that they would compare themselves to local Canadian residents and would feel less competent. The women reported that they felt judged at times, because of their educational background, which turned their training years into a very stressful experience, one they would not

want to go back to. Hence, it also brings to light the attitudes and perceptions held about non-Canadian educational institutions, which should be addressed in order to create a more culturally safe environment.

Healthcare organizations should acknowledge the fact that Muslim women healthcare professionals are dealing with multitude of identities such as professional, religious, cultural etc,. In order to help bridge the gap the Muslim women feel with other professionals at work such as colleagues, nurses and other management staff, the organizations should promote emphasis on professional identity “especially their professional behavior and commitment” to their work in order to help them “experience themselves more as professionals” rather than “members of particular ethnic, racial, religious or national group” (Baum, 2007, p.884).

The study findings could also help healthcare organizations understand that creating equal treatment between professional to another professional is as important as doctor-to-patient relation within the healthcare context. “Practitioners should be aware of their relative power by virtue of their professional role” within the medical care team (Baum, 2007, p.884). The study illuminates light on the power dynamics that exist in different contexts within the healthcare framework. Hence, in order to promote more equality within the healthcare environment, “practitioners should acknowledge the differences with respect, which would increase their empathy and enable them to see the other person as an individual rather than as a member of a different group” (Baum, 2007, p.884).

Research

The findings of this study provide insights into the experiences of the Muslim

women healthcare professionals in Canada. Much of the current research in this area is focused on Muslim women receiving care and the challenges that they have to face because of their religious and cultural practices. Most current studies related to the topic of the Muslim women give much attention to religious factors which supposedly play a predominant role in shaping the experiences of the Muslim women. However from the findings of this study it could be stated that other factors such as culture, social relations, economic, class, and education also shape the experiences of the Muslim women in the Canadian environment. Previous literature indicated Muslim women's religious background as a hurdle in the Western environment, but this study highlights the importance of Islamic faith as an important tool in helping the women become resilient and challenge the traditional stereotypes they face (Ahmad et al., 2003).

This study reaffirms the importance of effective dialogue in helping the women define and strengthen their critical vantage points against those whose perceptions of hijab are influenced by the media post September 11th world (Droogsma, 2007). "Indeed, communication that confirms and/or attempts to deny women's experiences encourages critical reflection/research and the assignment of meaning to these experiences" (Droogsma, 2007, p.312).

The findings of this study encourage the people of the Canadian society who have limited knowledge about the practices of the Muslim population to "seek out sources other than the mainstream media to better understand the experiences of the Muslim women and look beyond the dominant discourses which the women in this study hope to disrupt" (Droogsma, 2007, p.316).

In the case of Muslim immigrant women, the findings of this study indicate the

importance of different aspects in the Muslim women's lives that would increase their sense of belonging to the host country. An in-depth study of the influence of education during the Muslim women's acculturation phase in the new environment could further add to the knowledge base in this area.

Finally, I did qualitative research which pointed to the need to address the groups of all marginalized women, not just Muslim women. Studies that contribute to the understanding of women who are not integrated into the system or the ones who are coming to settle in Canada would add to the knowledge base. Future research in this area using quantitative studies with large cohorts would be quite helpful.

Strengths and Limitations of the Study

Of the best of my knowledge there has not been a previous study done on the experiences of Muslim women healthcare professionals in Canada. The findings of this study provide valuable insights into the challenges and the experiences of the Muslim women and help to deconstruct some of the misconceptions people have about the status of women in Islam. The situational hardships that Muslim women face can inform healthcare organizations, educational programs, other healthcare professionals, policy makers, community leaders, and the general population about the beliefs and cultural practices of the Muslim women. As a result, it can help them better understand the perspectives of these Muslim women, and thereby, create a culturally competent and safe work environment that promotes individual and social growth.

One of the strengths of this study is that it brings to light the notion that Muslims are not a homogenous group; hence their practices cannot be generalized. Second, this study presents the role of Islam faith in the Muslim women's lives as a source of support

and agency, rather than the traditional image of weakness and oppression. Findings of this study also heighten one's understanding of the notion that there are many other factors that play an important role in shaping the experiences of the Muslim women in the Canadian society other than religion, such as culture, social class, political, economic, and educational aspects.

Further, this study included women who came to Canada as immigrants and international students but also one participant who grew up in Canada, further adding to the understanding that although these women had different backgrounds, they sometimes have similar experiences of isolation and prejudice.

Another strength of this study is derived from the fact that I, myself, belong to the same religious (and for some, cultural) background as the women who participated in this study. Accepting the role of the insider within the design of this research study provided me with additional information and insights into the experiences of these Muslim women, which helped me better understand the unique set of challenges they had to face during their journey in the Canadian environment.

This study framed the participants' stories from the narrative inquiry perspective with a small sample size. "The goal of most qualitative studies is not to generalize but rather to provide a rich, contextualized understanding of some aspect of human experience through the intensive study of particular cases" (Polit & Beck, 2010, p. 1453). Narrative studies emphasize on the importance of dialogue, because an individual never lives in isolation, their meanings are always related to others (Moen, 2006), so when Muslim women talked about their experiences, they are helping create knowledge based on their interactions with others. Thus, a "voice is overpopulated with other voices, with

the intentions, expectations, and attitudes of others” (Moen, 2006, p.58). Narrative research adds to the understanding of the experiences of the Muslim women even considering the small sample size because this mode of inquiry views stories as “both enabled and constrained by a range of social resources and circumstances within the narrator’s community, local setting, organizational and social memberships, and cultural and historical location” (Chase, 2005, p.658). Therefore, higher emphasis is placed on acknowledging “differences and similarities in views of reality” (Clandinin & Huber, p.14). Hence, the knowledge developed from an inquiry with a small sample size, may further help highlight the relationship between experience and context, and the liaison between researchers and participants that could shape meaningful borders, rather than lead to generalizations about this group (Clandinin & Huber).

One of the limitations of this study was the availability of the participants for a second interview that could clarify some aspects of the first encounter. Although contact was made after the first interview, a meeting date could not be materialized because of the participants’ busy professional schedule. Second, Muslim women may have overlooked some of the information about the practices or beliefs about the Muslims assuming that as a Muslim researcher myself, I would be aware of it, which may have hampered the richness of the data. In addition, due to the issue of confidentiality and privacy, crucial information about the participants’ background and work location was altered in order to disguise their identity, which may have contributed to lack of clarity of some reported experiences, considering the impact that location and cultural background can have in shaping the experiences of these women.

Another limitation of this study was the fact that the Muslim women interviewed belonged to a healthcare profession that yields high socio-economic status, thus contributing to a rather smoother transition in order to establish themselves in the Western society, which may be different for Muslim women from different professions, also within different healthcare contexts.

Reflections on My Story after Completion of the Project

For me, this research study has a lot of personal significance because through the narratives of these women, I can find my own voice. I understand the challenges and struggles they faced when they chose to identify themselves as Muslims. I understand their desire to challenge the stereotypes people have about Muslim women, because I have been in places myself where people would see me as oppressed because of the hijab. But, like the experiences of these women, I have also seen the positive aspects of living in the Canadian society, where people are open-minded enough to understand that your religious values should not be an indication of your intellectual capabilities and hence, they provide you with opportunities to cultivate your career and personal goals, for which I am extremely grateful. Throughout the years of living in Canada, I have come to this junction in my life today, where I can tell people I am a Canadian Muslim because I strongly identify with the Canadian values of freedom, personal autonomy, and tolerance; as they also coincide with my Islamic values.

Conclusion

This study presents the experiences of Muslim women as successful, career-oriented healthcare professionals in Canada and the ways they navigated through the challenges in their work environment. Looking at this study from the critical lens

unravels power dynamics and social structures that may further complicate the struggles of a group considered to be in the margins of the society which portrays them as oppressed and vulnerable. The critical narrative inquiry approach opens up space for effective dialogue that can lead to positive social change in healthcare organizations, educational institutions, and practices. This study provides an opportunity to raise awareness about political perspectives about Muslim women and, at the same time, help bridge the gap in terms of the images Western people have about Islam. This study also provided space for the Muslim women to voice their concerns, as well as expresses their sources of strength and agency in facing the challenging situations in the Canadian healthcare environment. Further, this study highlights the importance of factors other than religion such as culture, education, and socio-economic status that play an important role in shaping the experiences of the Muslim women. Future research regarding the experiences of Muslim women from different walks of life, and socio-economic status and its implications within the context of the Canadian society should be further explored.

This study also highlights the advantages of the Canadian society in facilitating positive changes within these participants' lives by providing opportunities for growth to individuals with great potential. In addition, this study informs healthcare organizations, education, research, and healthcare professionals and policy makers, beside the general population about ways through which Muslim women negotiate and define their identities in the Canadian healthcare context.

It is hoped that the knowledge gained from this study can help address the issues of Muslim women as health care practitioners in order to help initiate changes that can

lead to more opportunities and exposure for Muslim women in the West, and enable them to provide more culturally meaningful, competent, and sensitive care.

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APPENDICES

Appendix A: Table 1

Summary table of the articles related to the experiences of Muslim women in the West

Study	Country Studied	Type of study	Group studied	Results
Bartkowski & Read (2000)	United States	Qualitative	Muslim Women	“Both the veiled and unveiled Muslim women exercise agency in crafting their gender identities” (p.411)
Byng (2010)	United States	Review	Muslim Women who wear the Headscarf	Newspaper stories helped promote the idea the Muslim women would not be considered as part of the American public
Cole & Ahmadi (2003)	United States	Qualitative	Muslim women who wear the Headscarf on College Campuses	Some Muslim women questioned the act of veiling and prioritized different forms of modesty to better assimilate themselves in the American society. While others continued to wear the wear to school as

				they considered it to be an integral part of Islamic code of modesty
Cooke (2008)	United States	Review	Muslim women	Muslim women are redefining themselves in the American society in ways that allow them to endorse the values of being an 'American' as well as 'Muslim' at the same time
Dwyer (2009)	UK	Qualitative	Young British Muslim women	The study highlighted the different ways through which young Muslim women renegotiated their identities. The hijab became a symbolic representation in helping them redefine themselves in a Western environment
Fonte & Horton-Deutsch (2005)	United States	Review	Immigrant Muslim women	Provides insights into the Islamic traditions of the Muslim women in order to help create culturally meaningful environment
Hammoud, White & Fetters (2005)	United States	Review	Arab American Muslim patients	Highlights the importance of create a

				culturally competent environment by informing healthcare, practices about the beliefs of the Muslim population, especially women
Korteweg (2008)	Canada	Review	Muslim Women	Presents the notion of agency within the Islamic traditions as viewed by the Muslim women
Saraglou, Lamkaddem, Pachterbeke & Buxant (2009)	Belgium	Qualitative	Muslim Women	The study findings highlight the notion that negative attitudes are intense toward the veiled Muslim women
Odeh Yosef (2008)	United States	Review	Arab Muslims	Review sheds light on the misconceptions people have about the practices of the Muslim population, especially related to issues of modesty and gender preferences.

Appendix B: Table 2 - Summary table of the studies examining perspectives of Muslim women who wear the veil in professional setting

Study	Study Data	Focus of the Study	Findings
Saraglou, Lamkaddem, Pachterbeke & Buxant (2009)	Two studies were conducted based on data carried out in Belgium in 2009	Investigate majority members' attitudes towards the religious traditions of Muslim women, role of acculturation	Results revealed the effects of prejudice/racism to be greater towards Muslim women who veiled – which acts as an identity marker
Cole & Ahmadi (2003)	Study data was based on the experiences of 7 Muslim women who veiled on large on a large college campus in US	Focus of the study was on women who veiled on a large college campus in the US	Results varied based on the level of faith of each woman. Some participants reevaluated and subsequently unveiled due to their college experiences
Dwyer (2009)	Data drawn from the experiences of young Muslim women in school in the UK	Explore the ways in which embodied differences are negotiated in the construction of identity	Findings reveal that young Muslim women are in the process of constructing 'hybrid' identities by trying to merge Islamic concept of modesty into their Western way of living
Khalifa, Kulwicki & Moore (2008)	Thirty-four Arab American nurses completed a survey about perceptions and experiences related to discrimination before and after the terror attacks on 9/11	The purpose of this article is to determine the effects of 9/11 on Arab American nurses' workplace discrimination in the Detroit metropolitan area	Most participants did not experience demotion, but some experienced intimidation and patient rejection more often

Appendix C: Letter of Information and Consent Form

Letter of Information

Experiences of Muslim women as health care professionals in Canada

Principal Investigator:

Dr. Lilian Magalhaes, PhD

Quratul Siddiqui, MSc. Candidate 2011 (Student Researcher)

Faculty of Health Sciences, University of Western Ontario



Letter of information - Interviews

This letter of information is for Muslim women health care professionals who we are inviting to participate in this research. We invite you to take part in this study that will explore the experiences of Muslim women professionals within the health care environment. This letter contains information to help you decide whether or not to participate in this study. It is important for you to understand why this study is being conducted and what it will involve. Please take the time to read over this material and feel free to ask questions if anything is unclear.

What is the purpose of this study?

Professor Lilian Magalhães, PhD, and Quratul Siddiqui, MSc. Student researcher, from the University of Western Ontario, are conducting a research study to find out more about the experiences of Muslim women as health care professionals in Canada. We are interested in how you make sense of and give meaning to your experience, and social factors were experienced in your professional lives.

Why have you been contacted?

You have been asked to take part because currently you are a Muslim women health care professional in Canada.

What is involved if you choose to participate?

If you agree to be in this research study, the following will happen to you. The research study will be conducted at your convenience. Participation involves two face to face interviews. The initial interview will take place at a setting of your preference and will last about 2 hours. During the first interview, you will be asked to tell the story of your experiences as a Muslim women health care professional in Canada. During the second interview you will be asked to clarify questions around issues you discussed in the previous interview as well you will have time to discuss anything else you may feel is relevant to your story as health care professional in Canada. You will be emailed or mailed a copy of the transcripts from each of your interviews and be given the opportunity to remove/change/withdraw any information you are uncomfortable with. You and I will set up a specific time to transfer/receive the transcripts to ensure that any third party bodies do not intercept the email. You may be able to withdraw your data up until the write up of the final report has begun.

Consent Form

Title of the Research: Experiences of Muslim Women as health care professionals In Canada

Principle Investigator: Dr. Lilian Magalhães, PhD.

Student Investigator: Quratul Siddiqui, MSc. student.

Name of Organization: University of Western Ontario, London/ON

I have read the letter of information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Print name of participant _____

Signature of participant _____

Date _____

Print Name of responsible for obtaining informed consent _____

Signature of responsible for obtaining informed consent _____

Date _____

Appendix D: Interview questions

1) QUESTIONS ABOUT BEING A MUSLIM WOMAN HEALTHCARE PROFESSIONAL

How does having an Islamic background influence your professional life?

How do you feel when you are being identified as a Muslim?

Could you tell me about your experience as a Muslim woman health care practitioner in Canada?

How does it affect your relationships with colleagues, patients and other staff members at work?

How do you think Islamic values and practices affect your work performance? Did you encounter any ethical problems related to Muslim values while working with diverse populations?

2) QUESTIONS ABOUT BEING A MUSLIM WOMEN (VEILED OR NOT)

What role do you think the act of veiling (if applicable) plays in shaping your experiences?

What is your experience with people's reaction to you being a Muslim woman?

What is your experience with people's reaction to you being a Muslim woman who wears the veil?

What are your perceptions and understanding of other people's culture and religious faith? Are there tensions or bridges?

3) QUESTIONS ABOUT BEING A MUSLIM WOMAN HEALTHCARE PROFESSIONAL IN RELATION TO ORGANIZATIONAL EFFECTIVENESS Part A)

How does your religious faith influence your professional activity?

Could you tell me about the process you went through to get into the Canadian health care system?

Did you have to face obstacles while getting into the Canadian health care system? What were your strengths in this process?

Tell me a little about your experience during your qualification (training) as a health professional? Could you give some examples?

What kind of opportunities do you think are available to Muslim women service providers in Canada?

Can you give some examples of the encounters between your cultural values and other people's values and practices?

What is your goal as a Muslim woman and a health care professional?

If you could fast 10 years forward, where would you want to be in your career?

PART B) Organizational effectiveness:

What does cultural competence look like to you?

How close do you think your organization come to that?

What changes would you recommend?

How could you contribute to make these positive changes?

Appendix E: Quality Considerations for a Narrative Study using Whittemore et al. (2000) Primary and Secondary Criteria

Primary Criteria	Quality Considerations
Credibility & Authenticity	<ul style="list-style-type: none"> - Results of the research will come straight from the narratives shared by the participants in order to reflect their experiences in a believable way - Interpretations will be trustworthy since participants chosen for the study have met the inclusion/exclusion criteria throughout the recruitment process to ensure the explanations fit the description - To ensure authenticity of the data, participants will be asked to give their feedback throughout the study to ensure that the “research reflects the meanings and experiences that are lived and experienced by the participants” (p.530)
Criticality & integrity	<ul style="list-style-type: none"> - Reflexive journal, subjectivity management with the help of my advisory committee, and critical analysis of all aspects of my inquiry will be done to explore any biases or ambiguities that might affect the rigor of the study - My own position and assumptions as a researcher will be discussed with the participants through an informal conversation which will take place prior to the interview - Knowledge claims made by the researcher will be substantiated by “recursive and repetitive checks” (p.531) of my interpretations to ensure they are aligned with the

	narratives of the participants
Secondary criteria of Validity	
Explicitness & creativity	<ul style="list-style-type: none"> - Verbatim of the narratives shared by the participants will be provided to ensure “explicit presentation of results” (p.531) is in tact - In order to make the process of findings more explicit, a detailed trail will be maintained – that will keep track of chronology of research activities and processes
Vividness & thoroughness	<ul style="list-style-type: none"> - “Thick and rich descriptions of the participants' stories will be presented in order to highlight salient features of themes” (p.531) - Saturation will be reached when the “research questions that are asked should be convincingly answered” (p.532). This will be done by ensuring that the interpretations of the researcher are consistent with the participants' narratives through on-going checks and with the help of semi-structured structured interviews to “ensure that the full scope of phenomenon is explored” (p.532) and “when the participants feel that the accurate meaning of their interpretations has been depicted” (p.531)
Congruence & Sensitivity	<ul style="list-style-type: none"> - All participants will have gone through the experiences of being a Muslim women health care professional in the West and will help address the issues they face in terms of the historical, social, political, and cultural/religious contexts. Thereby, examining the experiences of Muslim women as health care professionals will help voice their concerns and may

	<p>initiate dialogue which could yield positive changes for the Muslim community in Canada</p> <ul style="list-style-type: none">- Interviews will take place wherever its most comfortable for the participants and utmost emphasis will be given to ensure their privacy, dignity and respect is demonstrated throughout the study process.
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Appendix F: Ethics Approval



Office of Research Ethics

The University of Western Ontario
Room 5150 Support Services Building, London, ON, Canada N6A 3K7
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. L. Magalhaes

Review Number: 17714E

Review Date: January 12, 2011

Review Level: Expedited

Approved Local # of Participants: 6

Protocol Title: Experiences of Muslim Women as health care professionals in Canada

Department and Institution: Occupational Therapy, University of Western Ontario

Sponsor:

Ethics Approval Date: February 17, 2011

Expiry Date: December 31, 2011

Documents Reviewed and Approved: UWO Protocol. Letter of Information and Consent. Poster.

Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

- a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
- b) all adverse and unexpected experiences or events that are both serious and unexpected;
- c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert
FDA Ref. #: IRB 00000940

Ethics Officer to Contact for Further Information			
<input type="checkbox"/> Janice Sutherland (jsutherland@uwo.ca)	<input type="checkbox"/> Elizabeth Wambolt (ewambolt@uwo.ca)	<input checked="" type="checkbox"/> Grace Kelly (grace.kelly@uwo.ca)	

This is an official document. Please retain the original in your files.

cc: ORE File

Curriculum Vitae

Quratul Ain Siddiqui

London, Ontario

1. Academic

2009-2012 Master of Science, Candidate, Health Professional
Education
Faculty of Health Sciences
The University of Western Ontario

Conferred 2009 Honours Bachelor of Business Administration
Schulich School of Business
York University

2. Experience

Winter 2011 **Teaching Assistant** at the University of Western Ontario.
Graduate course: Methods in Evidence-Based Practice

Responsibilities: Holding office hours, guest lecture March 8, 2011, grading assignments and invigilating exams.

Spring 2008 **E-Learning Assistant** at York University.

Responsibilities: Prepared course computing/instructions and programme materials, provided technical/administrative support to students, faculty, and staff members.

Fall 2007 **Research Assistant** at York University.

Responsibilities: Data entry, labeling, assisted the department in promoting events, creating posters.

Fall 2007 **Academic Assistant** at York University.

Responsibilities: Take lecture notes for students with disabilities.

3. Awards and Honours

Sept. 2010-2011	Western Graduate Research Scholarship, The University of Western Ontario
Sept. 2009-2010	Western Graduate Research Scholarship, The University of Western Ontario
Jan. 2011	Graduate Teaching Assistantship, The University of Western Ontario
Sept. 2005	Received \$4000 York Entrance Scholarship
Sept. 2005	Received \$3000 Queen Elizabeth Scholarship
June 2005	Graduated High School with Honours from C.W. Jeffreys Collegiate Institute
June 2005	Received \$1000 award for the highest average student from C.W. Jeffreys Collegiate Institute